L'AGORA' PENITENZIARIA 2019

XX Congresso Nazionale SIMSPe-ONLUS

"Il carcere è territorio"

LA PSICHIATRIA IN AMBITO FORENSE E PENITENZIARIO

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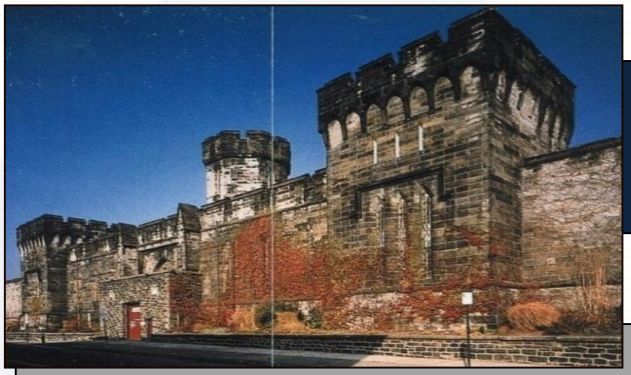
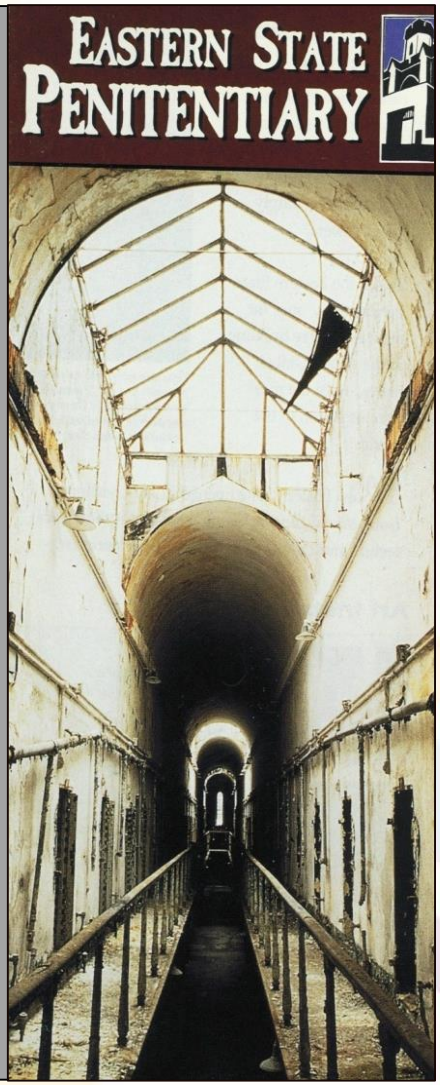
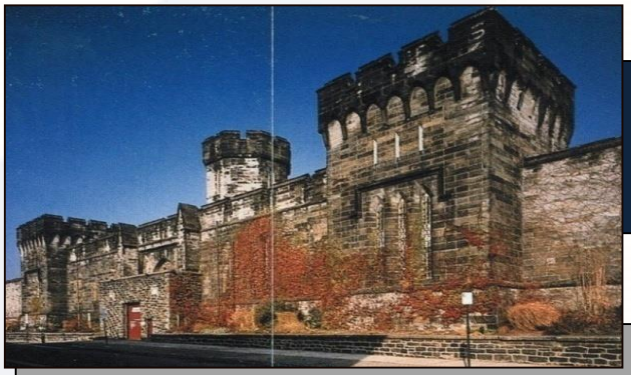


Segnalibro

- Carcere e disturbi mentali: un problema che viene da lontano
- Correlati clinici del reato: disturbi, sostanze, violenza e autolesività
- Alcune esperienze di psichiatria penitenziaria
- Un agenda per il futuro: implicazioni organizzative della salute mentale in carcere





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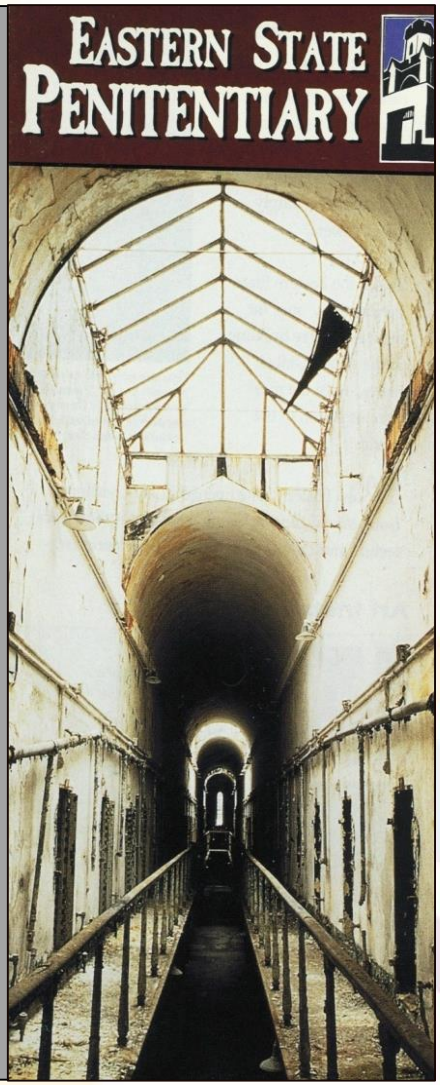
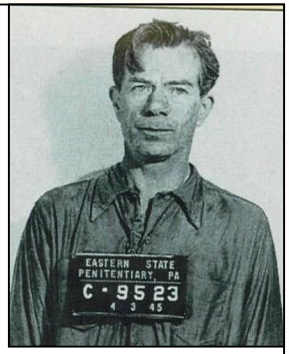


VIEWPOINT

Improving Long-term Psychiatric Care
Bring Back the Asylum



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During the past half century, the supply of inpatient psychiatric beds in the United States has largely vanished. In 1955, 560 000 patients were cared for in state psychiatric facilities; today there are fewer than one-tenth that number: 45 000.[1] Given the doubling of the US population, this represents a 95% decline, bringing the per capita public psychiatric bed count to about the same as it was in 1850—14 per 100 000 people.[1] A much smaller number of private psychiatric beds has fluctuated since the 1970s in response to policy and regulatory shifts that create varying financial incentives.

As a result, few high-quality, accessible long-term care options are available for a significant segment of the approximately 10 million US residents with serious mental illness. This population includes adults who are assessed as lacking insight and chronically psychotic, unable to care for themselves, and potentially dangerous to themselves and the public. These persons frequently have refractory schizophrenia and bipolar disorder. The void is both ethically unacceptable and financially costly.

Transinstitutionalization

Deinstitutionalization has really been transinstitutionalization. As state hospitals were closed, patients with chronic psychiatric diseases were moved to nursing homes or to general hospitals where they received episodic psychiatric treatment at significantly higher costs. Others became homeless, utilizing hospital emergency departments for both care and housing. Indeed, the current crisis in Nevada—where the lack of psychiatric beds has resulted in overcrowded emergency departments filled to capacity with psychiatric patients—may be a harbinger of the future. Most disturbingly, US jails and prisons have become the nation's largest mental health care facilities. Half of all inmates have a mental illness or substance abuse disorder; 15% of state inmates are diagnosed with a psychotic disorder.[3]

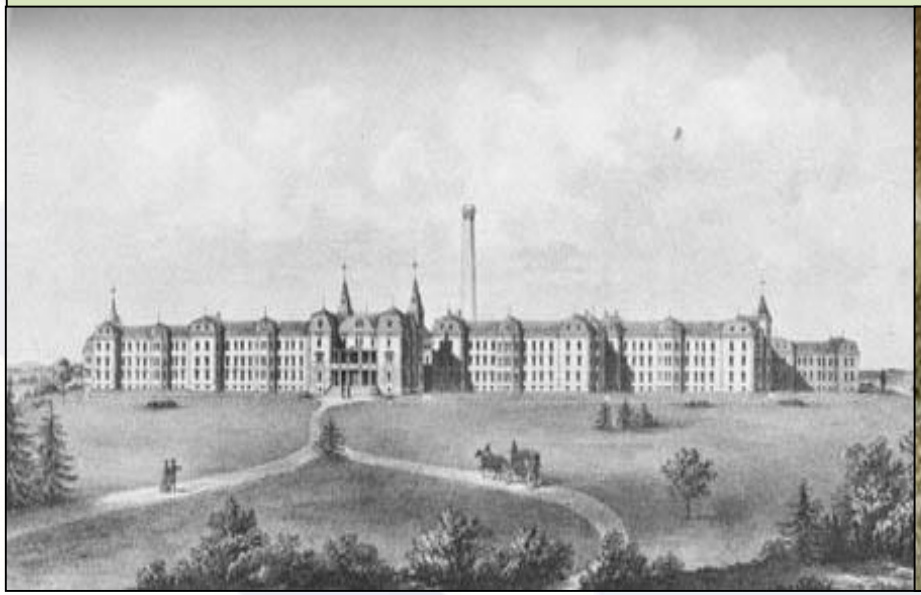
These are not new problems. Dorothea Dix, Moses Sheppard, Thomas Scattergood, and other 19th-century reformers had decried transinstitutionalization of the severely mentally ill into jails and almshouses. They called for a new kind of refuge in which mentally ill per-

Sisti et al, *JAMA* 2015

…l'istituzione carceraria è forse l'espressione non dichiarata della necessità di un sistema "stabile" di istituzionalizzazione asilare nella società post-industriale avanzata…?

ipotizzata relazione inversa tra disponibilità di posti letto in ospedali psichiatrici e numero di detenuti

(Penrose, 1939)



Gilligan, The last mental hospital; *Psychiatric Quarterly* 72, 45-61; 2001

Konrad, Prisons as new asylums; *Current Opinion in Psychiatry* 15, 583-587; 2002

Psychiatric Disorders and Crime in the US Population: Results From the National Epidemiologic Survey on Alcohol and Related Conditions Wave III

THE JOURNAL OF CLINICAL PSYCHIATRY

Kelly E. Moore, PhD; Lindsay M. S. Oberleitner, PhD; Howard V. Zonana, MD; Alec W. Buchanan, MD; Brian P. Pittman, MS; Terril L. Verplaetse, PhD; Gustavo A. Angarita, MD; Walter Roberts, PhD; and Sherry A. McKee, PhD

J Clin Psychiatry 2019;80(2):18m12317

Table 5. Association of Current Psychiatric Disorders With Current Crime Outcomes Adjusted for Sociodemographic Characteristics and Other Disorders (N = 36,309)

	Current[a] Legal Problems			Current[a] Alcohol-Related Legal Problems			Current[a] Drug-Related Legal Problems		
Current Diagnosis	%[b]	AOR[c]	95% CI	%[b]	AOR[c]	95% CI	%[b]	AOR[c]	95% CI
No diagnosis	0.78	Reference	...	0.13	Reference	...	0.83	Reference	...
Any diagnosis	3.85	3.94[d]	3.24–4.79	2.26	12.22[d]	6.40–23.34	3.59	3.73	1.84–7.57
Any mood disorder	4.04	1.78[d]	1.40–2.27	1.55	0.98	0.63–1.54	3.75	1.51	0.94–2.41
Major depressive disorder	3.76	1.68[d]	1.31–2.16	1.21	0.82	0.46–1.48	3.64	1.40	0.80–2.48
Persistent depressive disorder	4.39	1.54	1.08–2.21	2.07	1.35	0.68–2.67	3.21	1.40	0.59–3.37
Bipolar I disorder	5.58	1.50	0.87–2.60	2.93	1.30	0.58–2.92	4.13	1.18	0.55–2.55
Any anxiety disorder	3.30	1.37	1.02–1.85	1.09	0.66	0.44–0.97	3.14	0.91	0.53–1.58
Generalized anxiety disorder	4.30	1.79	1.27–2.54	1.13	0.75	0.39–1.44	3.11	0.96	0.51–1.82
Social anxiety disorder	3.78	0.96	0.62–1.49	1.27	0.60	0.27–1.36	4.98	1.60	0.82–3.12
Specific phobia	2.51	1.07	0.74–1.57	0.94	0.43	0.24–0.78	2.49	0.75	0.36–1.58
Panic disorder	4.71	1.08	0.72–1.60	1.54	1.00	0.52–1.94	4.55	1.28	0.58–2.80
Agoraphobia	4.01	0.90	0.52–1.58	1.77	0.97	0.40–2.34	5.52	2.09	0.84–5.21
Eating disorders[e]	1.55	0.41	0.16–1.08	1.01	1.03	0.29–3.69	2.06	0.92	0.20–4.17
Posttraumatic stress disorder	4.89	1.29	0.92–1.82	1.86	1.05	0.64–1.72	5.05	1.82	1.12–2.96
Schizophrenia/psychosis	8.31	2.18	1.14–4.19	2.80	1.22	0.43–3.48	4.17	1.12	0.33–3.75
Any substance use disorder	6.06	3.53[d]	2.83–4.40	3.89	22.92[d]	12.07–43.53	4.22	2.88	1.62–5.11
Alcohol use disorder	5.96	3.22[d]	2.58–4.02	4.17	18.55[d]	10.27–33.51	3.60	0.99	0.68–1.45
Any drug use disorder	10.36	3.27[d]	2.57–4.17	5.71	5.04[d]	3.34–7.62	5.99	3.14[d]	1.98–4.99
No. of diagnoses[f]									
1	2.73	2.77[d]	2.20–3.49	1.94	10.79[d]	5.60–20.77	2.39	2.68	1.21–5.92
2	4.32	4.84[d]	3.63–6.46	2.13	12.55[d]	5.74–27.44	3.65	3.35	1.55–7.26
3 or more	6.80	6.71[d]	5.14–8.76	3.38	16.74[d]	8.48–33.05	5.29	5.70[d]	2.64–12.32
Comorbid substance use and mental health disorders[g]									
Substance use disorder only	5.04	4.16[d]	3.20–5.39	4.16	20.80[d]	10.62–40.74	3.80	3.62	1.74–7.52
Mental health disorder only	1.82	2.32[d]	1.76–3.06	0.07	0.20	0.05–0.77	1.24	2.03	0.70–5.84
Both	7.73	7.03[d]	5.46–9.04	3.45	14.77[d]	7.16–30.45	4.73	4.74[d]	2.15–10.45

[a]Refers to the past 12 months.
[b]Unweighted percentages.
[c]Odds ratios are adjusted for sex, age, race/ethnicity, educational attainment, marital status, personal income, urbanicity, and region in addition to other psychiatric disorders.
[d]Combined prevalence of anorexia nervosa, bulimia nervosa, and binge-eating disorder.
[e]These models controlled for sociodemographic characteristics only. Reference category for these analyses is "no diagnoses" (n = 18,548).
[f]$P < .001$.
Abbreviation: AOR = adjusted odds ratio.

Objective: Current knowledge regarding the intersection of psychiatric disorders and crime in the United States is limited to psychiatric, forensic, and youth samples. This study presents nationally representative data on the relationship of *DSM-5* psychiatric disorders, comorbid substance and mental health disorders, and multimorbidity (number of disorders) with criminal behavior and justice involvement among non-institutionalized US adults.

Methods: Data were drawn from the National Epidemiologic Survey on Alcohol and Related Conditions Wave III (NESARC-III; 2012–2013; N = 36,309). Logistic regressions were used to examine the association of specific disorders (eg, mood, anxiety, eating, posttraumatic stress, substance use), comorbid substance use and mental health disorders, and multimorbidity with lifetime criminal behavior, incarceration experience, and past-12-month general, alcohol-related, and drug-related legal problems.

Results: Overall, 28.5% of participants reported a history of criminal behavior, 11.4% reported a history of incarceration, 1.8% reported current general legal problems, 0.8% reported current alcohol-related legal problems, and 2.7% reported current drug-related legal problems. The presence of any disorder was associated with a 4 to 5 times increased risk of crime outcomes. Drug use disorders were associated with the highest risk of lifetime crime (adjusted odds ratio [AOR] = 6.8; 95% CI, 6.1–7.6) and incarceration (AOR = 4.7; 95% CI 4.1–5.3) and current legal problems (AOR = 3.3; 95% CI, 2.6–4.2). Multimorbidity and comorbid substance use and mental health disorders were associated with additional risk. Controlling for antisocial personality disorder did not change the findings.

Conclusions: Community adults with substance use disorders, comorbid substance use and mental health disorders, and increasing multimorbidity are most at risk of crime and justice involvement, highlighting the importance of community-based addiction treatment.

THE JOURNAL OF CLINICAL PSYCHIATRY CME Institute JCP PCC

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Psychiatric Disorders and Crime in the US Population: Results From the National Epidemiologic Survey on Alcohol and Related Conditions Wave III

Kelly E. Moore, PhD; Lindsay M. S. Oberleitner, PhD; Howard V. Zonana, MD; Alec W. Buchanan, MD; Brian P. Pittman, MS; Terril L. Verplaetse, PhD; Gustavo A. Angarita, MD; Walter Roberts, PhD; and Sherry A. McKee, PhD

J Clin Psychiatry 2019;80(2):18m12317

https://doi.org/10.4088/JCP.18m12317

PROVE DI UTOPIA IN EUROPA

… L'abolizionismo ha una lunga storia anche in Europa e oggi vorrebbe dare risposte concrete ad una situazione insostenibile …

Dana Scruggs for The New York Times

FEATURE

Is Prison Necessary? Ruth Wilson Gilmore Might Change Your Mind

In three decades of advocating for prison abolition, the activist and scholar has helped transform how people think about criminal justice.

April 17, 2019 · By RACHEL KUSHNER

"All the News That's Fit to Print"

The New York Times

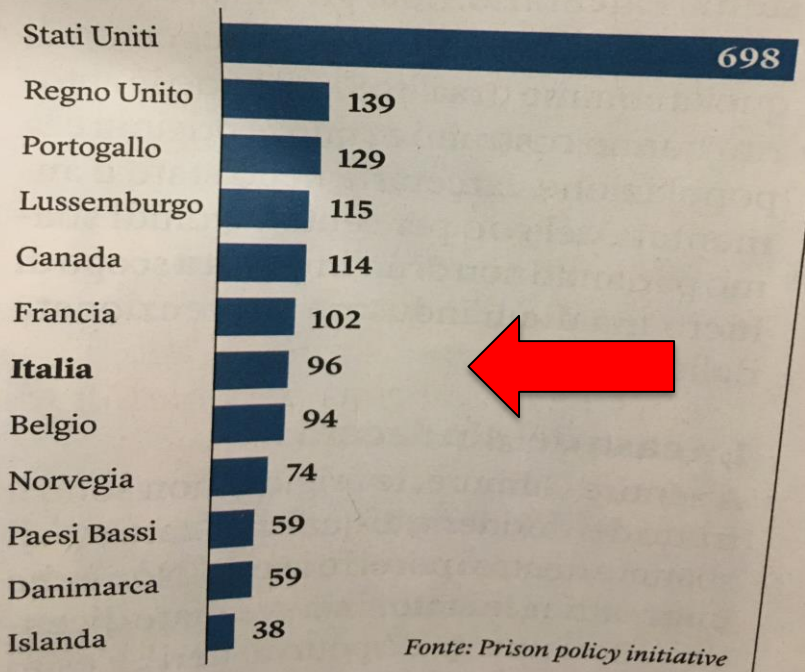
Late Edition

VOL. CLXVIII … No. 58,104 NEW YORK, WEDNESDAY, OCTOBER 3, 2018 $3.00

Da sapere

Geografia delle prigioni

Detenuti ogni 100mila abitanti in alcuni paesi della Nato, 2017

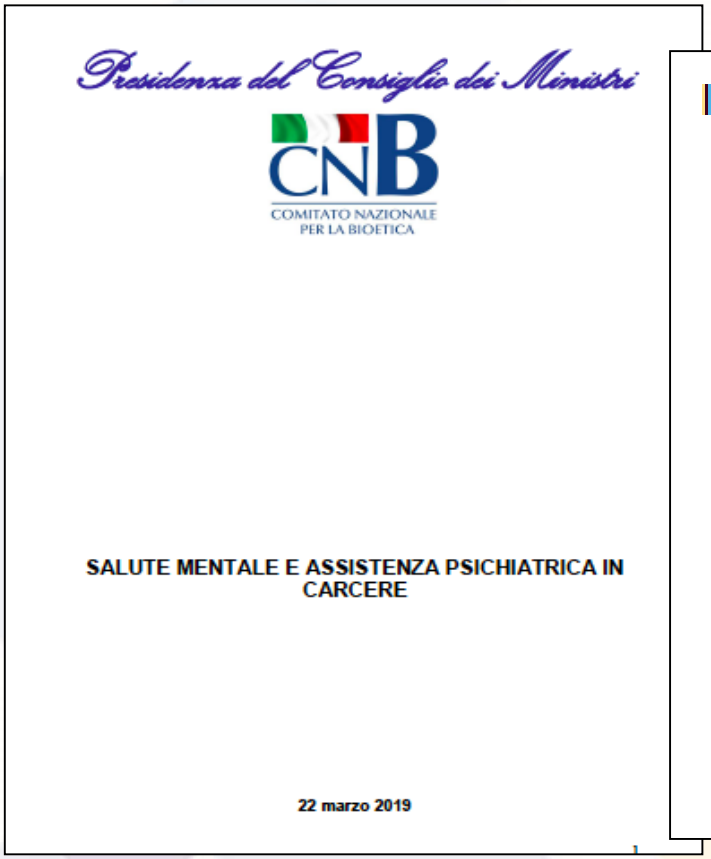


Fonte: Prison policy initiative

Non è vero che le prigioni rendono la società più sicura. Anche per questo è arrivato il momento di immaginare alternative più umane e più efficaci. Attivisti e studiosi sono convinti che mettere le persone in prigione sia un modo sbagliato per contrastare la violenza

(Shutterstock/Getty, 2019)

The New York Times Magazine


Presidenza del Consiglio dei Ministri

CNB
COMITATO NAZIONALE PER LA BIOETICA

SALUTE MENTALE E ASSISTENZA PSICHIATRICA IN CARCERE

22 marzo 2019

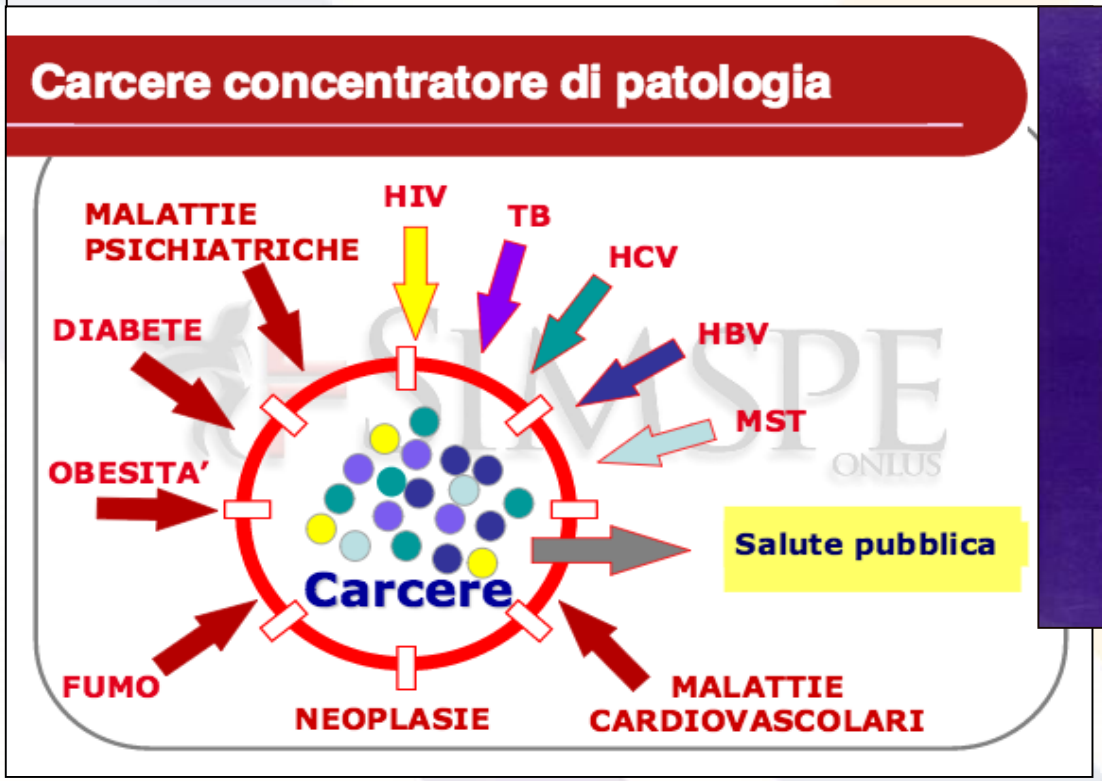
1

INDICE

Il carcere per sua natura comprime i diritti individuali, la salute mentale in particolare è insidiata dalla sofferenza legata allo stato di costrizione e di dipendenza totale del detenuto per qualsiasi necessità della vita quotidiana. Dall'incompatibilità fra il carcere e la salute mentale discende l'indicazione che la presa in carico delle persone con disturbo psichiatrico debba avvenire di regola al di fuori del carcere, nel territorio. La cura psichiatrica in carcere dovrebbe essere limitata alle persone con disturbi minori, oppure al ristretto numero di coloro per cui non sia possibile applicare un'alternativa alla carcerazione a fine terapeutico. Va inoltre ricordato che la salvaguardia della

LA SALUTE DEI DETENUTI IN ITALIA

La ***Società Italiana di Medicina e Sanità Penitenziaria*** *(SIMSPe, 2019)* fornisce periodicamente informazioni aggiornate sullo stato di salute della popolazione carceraria italiana: 48% malattie infettive; 30-35% problemi correlati all'uso di alcol/sostanze; 25-30% disturbi psichici maggiori, nonché formazione multiprofessionale. Specularmente, la ***Società Italiana di Psichiatria*** *(SIP, 2007)* - con le sue Sezioni Speciali ***SIP.Dip*** e ***SIPF*** - da anni concorre all'informazione ed alla formazione degli psichiatri sul tema "autori di reato" e sull'evoluzione del sistema di



PLOS ONE

RESEARCH ARTICLE

Violence risk and mental disorders (VIORMED-2): A prospective multicenter study in Italy

Stefano Barlati[1,2], Alberto Stefana[1], Francesco Bartoli[3], Gi… …ni[4], Viola Bulgari[5], Valentina Candini[5], Giuseppe Carrà[3], Co… Massimo Clerici[3,7], Marta Cricelli[8], Maria Teresa F… …ura Iozzino[5], Ambra Macis[9], Antonio Vita[1,2], Giovanni de … …-2 Group[11]

OPEN ACCESS

Citation: Barlati S, Stefana A, Bartoli F, Bianconi G, Bulgari V, Candini V, et al. (2019) Violence risk and mental disorders (VIORMED-2): A prospective multicenter study in Italy. PLoS ONE 14(4): e0214924. https://doi.org/10.1371/journal.pone.0214924

Editor: Kenji Hashimot…

Received: August 6, 2…

Accepted: March 23, 20…

Published: April 16, 2019

Abstract

Results

The sample included 247 outpatients, for a total of 126 cases and 121 controls. Compared to controls, patients with a history of violence had a greater frequency of lifetime domestic violence, a greater lifetime propensity to misuse substances, and a higher number of compulsory admissions. The forthnightly monitoring during the 1-year follow-up did show statistically significant differences in aggressive and violent behavior rates between the two groups. Verbal aggression was significantly associated with aggression against objects and physical aggression. Moreover, outpatients with an history of violence showed statistically significant higher MOAS scores compared to both residential patients with an history of violence, assessed in the first wave of this project, and all controls.

Conclusion

Patients with a hi… …nd showed a greater occurrence of additiona… …ar observation period. Our results may assist clinicians in i… …ed methods of patient assessment and violence monitoring in outpati… …ealth services and may prompt improved collaboration between different com…unity services.

Comunità confinata

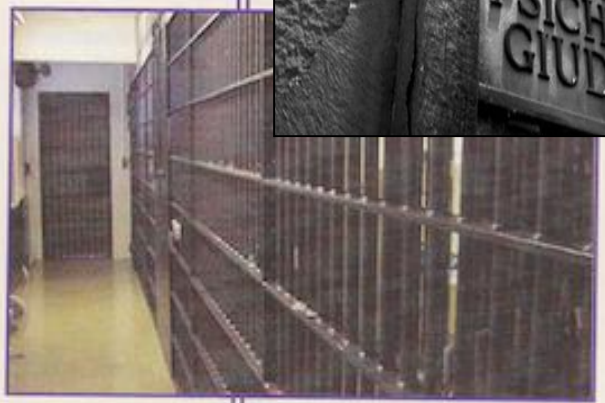
Carceri: medici "in prima linea"

di Sergio Fazioli
sergio.fazioli@libero.it

Legge 740/70: nasce il Sistema Sanitario Penitenziario (Ministero Giustizia)

Legge 833/78: nascita del Servizio Sanitario Nazionale (Ministero Salute)

D.Lgs 1°/04/08: il Servizio Sanitario Penitenziario transita nel S.S.N., ma resta in vigore la Legge 740/70, 30 anni dopo.



Le *Risor*... alle AA... ziaria, s... il contro... del pazi... sceglier... della pr... Il *sovra*... (66.000... cide sull... diana d... mentare... contagio... Carcere...

...zioni disfunzionali del... modificazioni dello s... tempo, il timing detent... dell'aria e nella chiusur... e nel rapporto con gli a... gli altri reclusi); **dipend**... zione dell'autonomia, ... dal contesto nei movim... il carcere. Ogni richiesta ... con il medico o con il di... catore deve essere scritt... dulo da autorizzare: il ... **attività consentite** (scuo... boratorio teatrale, attiv... quali la palestra o il calc... lavorativa solo per pochi); **modifi-**

ed economiche, doveva chiedere al direttore amministrativo del carcere tutto ciò che era necessario per curare i reclusi: dai farmaci alle attrez-

The milestones of the INSIEME Project

IMPROVING THE MANAGEMENT OF MENTAL HEALTH IN PROSONS

National Advisory and Scientific Board

Document Editing

«Percorso Diagnostico Terapeutico Assistenziale (PDTA) per il paziente con disturbo mentale negli Istituti Penitenziari italiani»

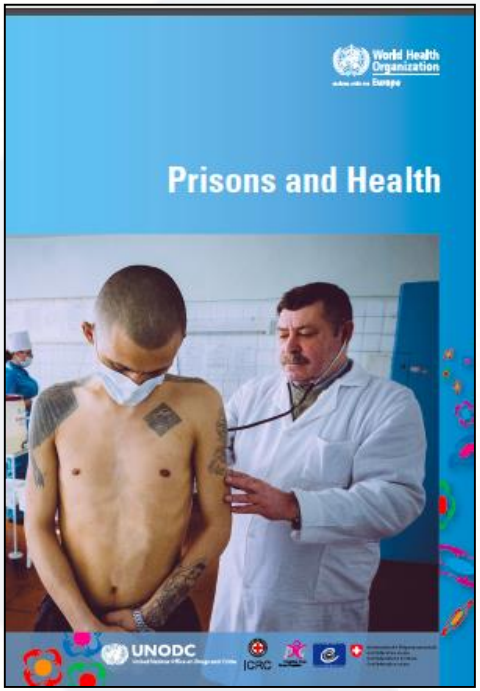
Training of professionals involved in the health management of the detainee

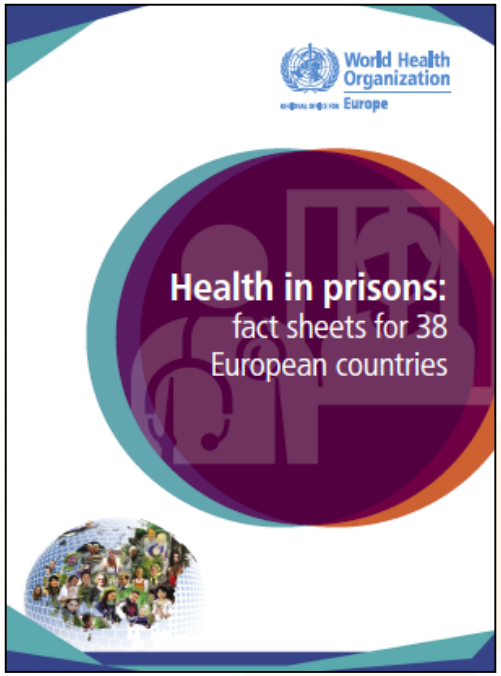
Educational campaign with involvement of Local Health Units and territorial partners

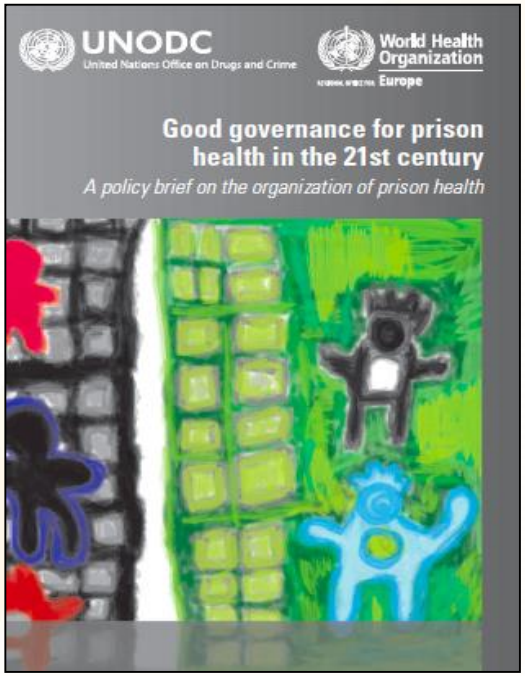
Percorso Diagnostico Terapeutico Assistenziale (PDTA)

RACCOMANDAZIONI PER Il PAZIENTE CON DISTURBO MENTALE NEGLI ISTITUTI PENITENZIARI ITALIANI

INDICE

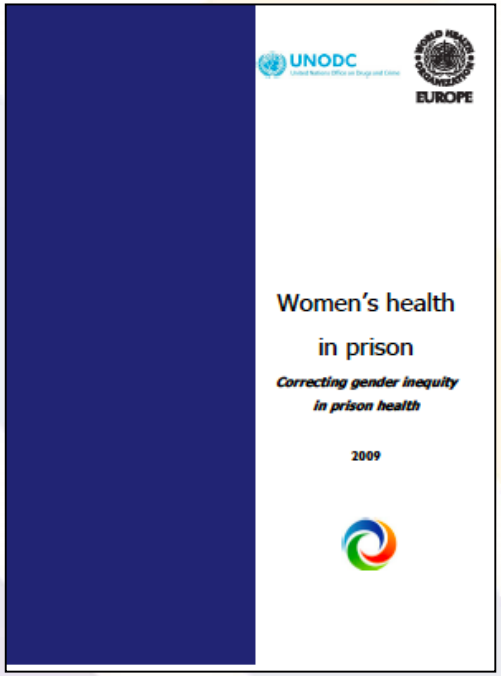


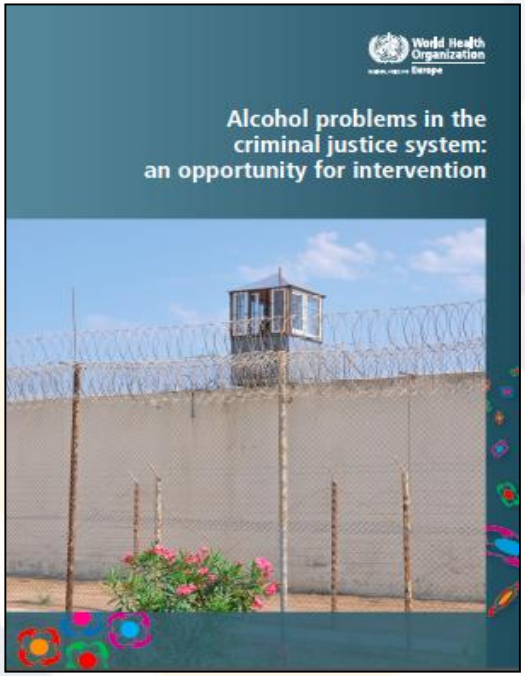




WHO

WORLD HEALTH ORGANIZATION





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Health topics > Health determinants > Prisons and health > Prisons and health: Partnership for Health in the Criminal Justice System

Prisons and health

News

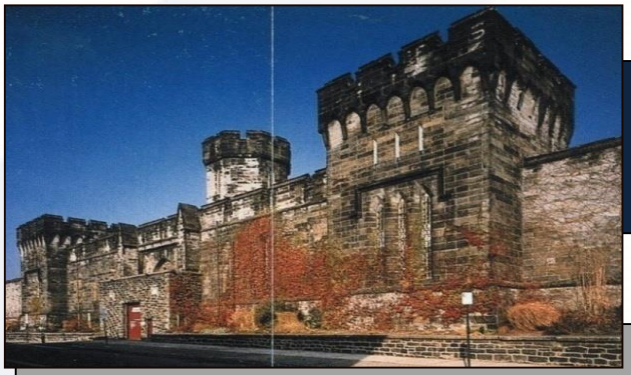
Prisons and health: Partnership for Health in the Criminal Justice System

5 14

The Partnership for Health in the Criminal Justice System website provides prison health-related resources supplied by WHO/Europe and partner organizations. It covers prison health information in the fields of: human rights and medical ethics, communicable diseases, noncommunicable diseases, risk factors and prison health management.

As members of the Partnership for Health in the Criminal Justice System, WHO/Europe and its partners share the following aims:

- to encourage cooperation and establish integrated work between public health systems, international nongovernmental organizations, and prison health systems to promote public health and reduce health inequalities;
- to encourage prisons to operate within the widely recognized international codes of human rights and medical ethics in providing services for prisoners;
- to help reduce reoffending by encouraging prison health services to contribute fully to each prisoner's rehabilitation, especially but not exclusively in relation to drug addiction and mental health problems;
- to reduce prisoners' exposure to communicable diseases, thereby preventing prisons from becoming focal points of infection;
- to encourage all prison health services, including health promotion services, to reach standards equivalent to those in the wider community;
- to promote a whole-of-government approach for the management and coordination of all relevant agencies and resources contributing to the health and well-being of prisoners; and
- to encourage health ministries to provide and be accountable for health care services in prisons and advocate healthy prison conditions.



Segnalibro

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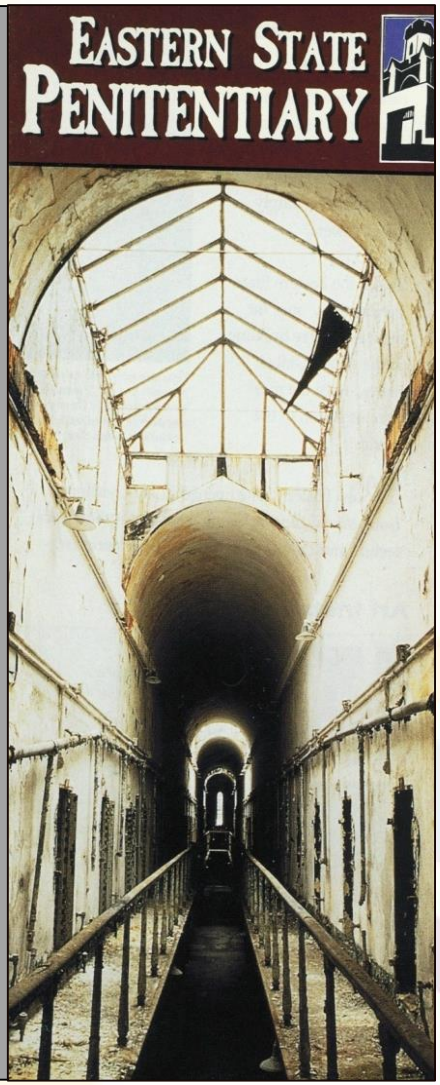

Lancet Psychiatry 2016; 3 (9); 871-81

Mental health of prisoners: prevalence, adverse outcomes, and interventions

Seena Fazel, Adrian J Hayes, Katrina Bartellas, Massimo Clerici, Robert Trestman

More than 10 million people are imprisoned worldwide, and the prevalence of all investigated mental disorders is higher in prisoners than in the general population. Although the extent to which prison increases the incidence of mental disorders is uncertain, considerable evidence suggests low rates of identification and treatment of psychiatric disorders. Prisoners are also at increased risk of all-cause mortality, suicide, self-harm, violence, and victimisation, and research has outlined some modifiable risk factors. Few high quality treatment trials have been done on psychiatric disorders in prisoners. Despite this lack of evidence, trial data have shown that opiate substitution treatments reduce substance misuse relapse and possibly reoffending. The mental health needs of women and older adults in prison are distinct, and national policies should be developed to meet these. In this Review, we present clinical, research, and policy recommendations to improve mental health care in prisons. National attempts to meet these recommendations should be annually surveyed.

Lancet Psychiatry 2016

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For *The Lancet* Series on HIV and related infections in prisoners see www.thelancet.com/series/hiv-in-prisons

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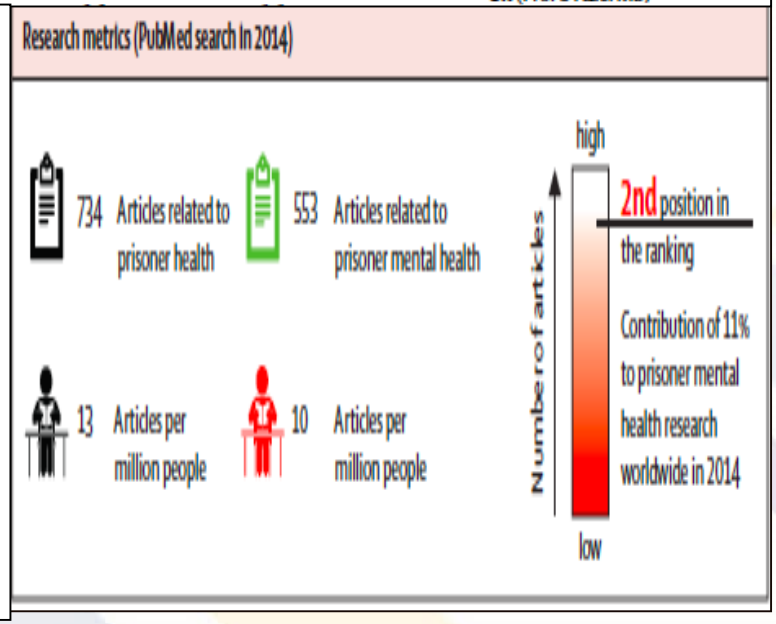
	Men	Women
Psychotic illness[1]	4% (3–4)	4% (3–5)
Major depression[1]	10% (9–12)	14% (10–18)
Alcohol misuse[2]	18–30%	10–24%
Drug misuse[2]	10–48%	30–60%

Data are % (95% CI) or %.

Table 1: Prevalence of different psychiatric diagnoses in adult prisoners based on systematic reviews



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Variable	Psychosis, % (95% CI)	Major depression, % (95% CI)
Overall	3.7 (3.2–4.1)	11.4 (9.9–12.8)
Gender of inmates		
Male	3.6 (3.1–4.2)	10.2 (8.8–11.7)
Female	3.9 (2.7–5.0)	14.1 (10.2–18.1)
Prisoner status		
Sentenced prisoners	3.7 (3.0–4.2)	10.5 (8.8–12.1)
Remand prisoners (detainees)	3.5 (4.2–6.8)	12.3 (9.5–15.1)
Country		
Low/middle income	5.5 (4.2–6.8)	22.5 (10.6–34.4)
High income	3.5 (3.0–3.9)	10.0 (8.7–11.2)

There were five publications since 2001 that reported rates of comorbidity in prisoners.[96,97,99,102,107] These rates ranged from 20.4 to 43.5% in those with any mental disorder who had comorbid substance misuse, from 13.6 to 95.0% in prisoners with psychotic illnesses with comorbid substance misuse, and 9.2 to 82.5% in individuals with mood disorders and major depression with concurrent substance misuse.

Fazel S. et al., Lancet Psychiatry 2016; 3 (9); 871-81

Prevalence of mental disorders in French prisons for men

Table 1: Prevalence estimates (with standard deviations) of DSMIV diagnoses.

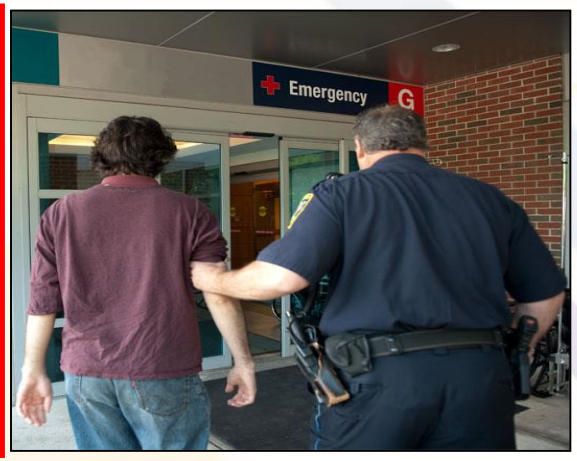
	Both clinicians	At least one	Consensus	MINI
Mood disorders	21.4 (3.9)	30.4 (5.2)	28.0 (4.5)	28.6 (4.6)
Major depressive disorder	17.9 (3.8)	26.1 (5.2)	24.0 (4.6)	22.9 (4.1)
Dysthymic disorder	3.2 (1.2)	7.0 (2.0)	4.8 (1.5)	1.5 (0.5)
Bipolar I or II disorder (lifetime)	2.0 (0.4)	3.9 (0.8)	3.1 (0.7)	1.3 (1.0)
Manic/hypomanic episode	2.1 (0.6)	7.5 (2.5)	3.6 (1.0)	4.2 (4.2)
Anxiety disorders	21.2 (4.3)	31.4 (5.5)	29.4 (5.2)	24.0 (4.1)
Panic disorder WaWA	3.7 (1.4)	6.7 (2.3)	5.1 (1.7)	3.9 (1.5)
Agoraphobia WHoPD	6.6 (2.0)	12.0 (3.6)	10.0 (3.0)	10.8 (3.4)
Social phobia	6.8 (1.7)	12.5 (3.0)	11.0 (2.6)	8.8 (2.1)
Obsessive compulsive disorder	3.7 (1.2)	7.9 (2.9)	5.5 (2.0)	5.7 (1.8)
Post traumatic stress disorder	9.7 (3.5)	15.8 (4.8)	14.2 (4.3)	6.6 (2.1)
Generalized anxiety disorder	12.0 (2.1)	19.6 (3.0)	17.7 (2.7)	15.4 (2.1)
Substance-Related dis. Disorders	14.0 (2.8)	20.8 (3.4)	19.1 (3.3)	14.1 (2.6)
Alcohol dependence	9.4 (1.9)	12.9 (2.4)	11.7 (2.3)	8.7 (1.7)
Drug dependence	10.8 (2.5)	16.2 (2.7)	14.6 (2.6)	8.9 (2.0)
Psychotic disorders	12.1 (3.0)	19.2 (5.0)	17.0 (4.6)	17.3 (4.5)
Schizophrenia	3.8 (1.0)	8.0 (2.6)	6.2 (1.8)	11.9 (4.0)
Brief psychotic or Schizophreniform dis.	0	0.2 (0.2)	0.2 (0.2)	0.3 (0.2)
Schizoaffective disorder	1.0 (0.4)	2.7 (1.1)	2.6 (1.1)	0.9 (0.4)
Delusional disorder	2.4 (0.6)	6.3 (1.8)	5.3 (1.6)	0.3 (0.2)
At least one disorder	27.4 (4.5)	37.7 (5.1)	35.9 (5.0)	33.9 (4.8)

Falissard B. et al., BMC Psychiatry 2006; 21;6:33

Association of Violence With Emergence of Persecutory Delusions in Untreated Schizophrenia

	Violent Incident After Release				Logistic Regression					
	No		Yes		Unadjusted			Adjusted[a]		
Diagnosis	N	%	N	%	Odds Ratio	95% CI	p	Odds Ratio	95% CI	p
No psychosis (reference)	586	79.4	156	21.6	1.00	—	—	1.00	—	—
Schizophrenia										
No treatment	8	50.0	8	50.0		1.39–10.19	0.009	3.43	1.10–10.72	0.034
Treatment during prison only	16	72.7	6	27.3	1.41	0.54–3.67	0.480	1.39	0.49–3.96	0.532
Continued treatment	40	75.5	13	24.5	1.22	0.64–2.34	0.544	1.40	0.66–2.97	0.380
Delusional disorder										
No treatment	3	75.0	1	25.0	1.19	0.12–11.50	0.881	0.71	0.07–7.38	0.778
Treatment during prison only	10	77.0	3	23.0	1.07	0.29–3.93	0.919	0.96	0.24–3.89	0.958
Continued treatment	13	92.9	1	7.1	0.27	0.04–2.11	0.214	0.23	0.03–1.81	0.161
Drug-induced psychosis										
No treatment	38	71.7	15	28.3	1.49	0.80–2.77	0.213	1.10	0.57–2.12	0.787
Treatment during prison only	8	53.3	7	46.7	3.29	1.18–9.22	0.023	2.59	0.88–7.61	0.083
Continued treatment	19	79.2	5	20.8	0.99	0.36–2.69	0.985	0.88	0.31–2.56	0.821

Conclusions: The results indicate that the emergence of persecutory delusions in untreated schizophrenia explains violent behavior. Maintaining psychiatric treatment after release can substantially reduce violent recidivism among prisoners with schizophrenia. Better screening and treatment of prisoners is therefore essential to prevent violence.



Keers R.et al., Am. J. Psychiatry 2014; 171, 332-339

A cross-sectional prevalence survey of psychotropic medication prescribing patterns in prisons in England

BNF subchapter	Community (reference group) n (%)	95% CI	Prisoners n (%)	95% CI	PR (95% CI) Crude	Adjusted
Men						
Hypnotics and anxiolytics	2082 (1.4)	1.3 to 1.4	62 (1.0)	0.8 to 1.3	0.74 (0.56 to 0.96)	1.27 (0.97 to 1.64)
Antipsychotics	2430 (1.1)	1.1 to 1.2	258 (4.3)	3.8 to 4.8	3.67 (3.21 to 4.18)	4.81 (4.21 to 5.50)
Antidepressants	4183 (4.6)	4.4 to 4.7	801 (13.2)	12.4 to 14.1	2.87 (2.66 to 3.10)	4.16 (3.84 to 4.50)
CNS stimulants	457 (0.0)	0.0 to 0.0	44 (0.7)	0.5 to 9.7	22.57 (16.17 to 30.79)	12.99 (9.48 to 17.80)
Any	6781 (5.8)	5.7 to 5.9	1024 (16.9)	16.0 to 17.9	2.90 (2.71 to 3.10)	4.02 (3.75 to 4.30)
Women						
Hypnotics and anxiolytics	3756 (2.5)	2.5 to 2.6	62 (7.9)	6.1 to 10.0	3.11 (2.38 to 4.00)	7.40 (5.73 to 9.55)
Antipsychotics	3295 (1.6)	1.5 to 1.6	92 (11.7)	9.6 to 14.2	7.49 (6.01 to 9.22)	12.74 (10.30 to 15.76)
Antidepressants	8858 (10.0)	9.8 to 10.2	323 (41.1)	37.7 to 44.7	4.09 (3.65 to 4.58)	5.55 (4.96 to 6.22)
CNS stimulants	335 (0.0)	0.0 to 0.0	4 (0.5)	0.0 to 0.1	22.29 (6.04 to 57.61)	19.01 (7.07 to 51.10)
Any	12,146 (11.8)	11.6 to 12.0	376 (47.9)	44.4 to 51.5	4.05 (3.65 to 4.49)	5.95 (5.36 to 6.61)

Antipsychotic prescriptions were more likely than prescriptions for other psychotropic medications to be accompanied by an invalid (not indicated) diagnosis in the patient notes (35.4% vs. 17.2%; PR 2.03, 95% CI 1.70 to 2.44). The most common invalid indications recorded for antipsychotic prescriptions were personality disorder ($n = 50$), anger/aggression (not associated with psychosis; $n = 16$) and anxiety ($n = 12$). Invalid indications recorded for antidepressant prescriptions included low mood ($n = 96$), insomnia ($n = 25$), anxiety ($n = 24$) and personality disorder ($n = 22$).

Hassan L.et al., Health Services and Delivery Research 2014; 2, 33

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Our review found that there were many more controlled trials of psychological treatments than medication in the prison setting. Psychological therapy trials were typically small, involved a wide variety of interventions (eg, cognitive behavioural, interpersonal, dialectical behavioural, meditation-based, and group therapies), and showed inconsistent findings. One study[57] of yoga in

Psychological treatments for substance misuse include attendance at therapeutic communities, cognitive behavioural therapy, and motivational interviewing. A meta-analysis of prison-based therapeutic communities suggested that participation increases treatment success, and that relapse and re-incarceration were most effectively reduced in individuals in therapeutic communities who received aftercare in the community.[65] A meta-analysis of moral reconation therapy, which focuses on moral reasoning and was originally a component of therapeutic communities, supported the notion that moral reconation therapy reduced recidivism.[66]

Am J Drug Alcohol Abuse. 2017 Jul;43(4):475-488. doi: 10.1080/00952990.2017.1303838. Epub 2017 Apr 4.

Evidence-based treatment and supervision practices for co-occurring mental and substance use disorders in the criminal justice system.

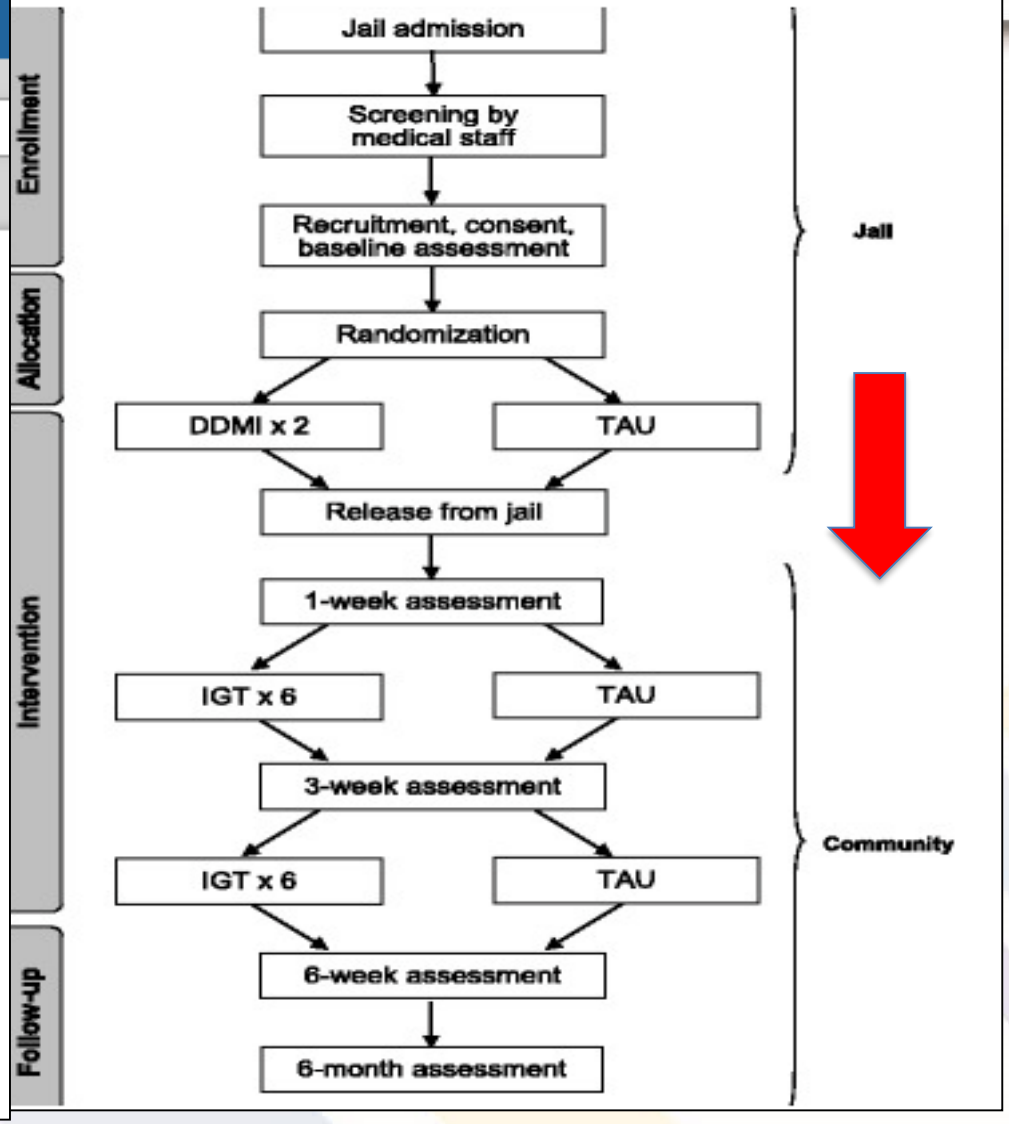
Peters RH[1], Young MS[1], Rojas EC[2], Gorey CM[2].

RESULTS: Several empirically supported frameworks are available to guide services for offenders who have CODs, including Integrated Dual Disorders Treatment (IDDT), the Risk-Need-Responsivity (RNR) model, and Cognitive-Behavioral Therapy (CBT). Evidence-based services include integrated assessment that addresses both sets of disorders and the risk for criminal recidivism. Although several evidence-based COD interventions have been implemented at different points in the justice system, there remains a significant gap in services for offenders who have CODs. Existing program models include Crisis Intervention Teams (CIT), day reporting centers, specialized community supervision teams, pre- and post-booking diversion programs, and treatment-based courts (e.g., drug courts, mental health courts, COD dockets). Jail-based COD treatment programs provide stabilization of acute symptoms, medication consultation, and triage to community services, while longer-term prison COD programs feature Modified Therapeutic Communities (MTCs).

CONCLUSION: Despite the availability of multiple evidence-based interventions that have been implemented across diverse justice system settings, these services are not sufficiently used to address the scope of treatment and supervision needs among offenders with CODs.

PMC full text: Trials. 2017; 18: 365.
Published online 2017 Aug 4. doi: 10.1186/s13063-017-2088-z

Fig. 2



Abstract

BACKGROUND: Adults with co-occurring mental and substance use disorders (CODs) are overrepresented in jails. In-custody barriers to treatment, including a lack of evidence-based treatment options and the often short periods of incarceration, and limited communication between jails and community-based treatment agencies that can hinder immediate enrollment into community care once released have contributed to a cycle of limited treatment engagement, unaddressed criminogenic risks, and (re)arrest among this vulnerable and high-risk population. This paper describes a study that will develop research and communication protocols and adapt two evidence-based treatments, dual-diagnosis motivational interviewing (DDMI) and integrated group therapy (IGT), for delivery to adults with CODs across a jail-to-community treatment continuum.

METHODS/DESIGN: Adaptations to DDMI and IGT were guided by the Risk-Need-Responsivity model and the National Institute of Corrections' implementation competencies; the development of the implementation framework and communication protocols were guided by the Evidence-Based Interagency Implementation Model for community corrections and the Inter-organizational Relationship model, respectively. Implementation and evaluation of the protocols and adapted interventions will occur via an open trial and a pilot randomized trial. The clinical intervention consists of two in-jail DDMI sessions and 12 in-community IGT sessions. Twelve adults with CODs and four clinicians will participate in the open trial to evaluate the acceptability and feasibility of, and fidelity to, the interventions and research and communication protocols. The pilot controlled trial will be conducted with 60 inmates who will be randomized to either DDMI-IGT or treatment as usual. A baseline assessment will be conducted in jail, and four community-based assessments will be conducted during a 6-month follow-up period. Implementation, clinical, public health, and treatment preference outcomes will be evaluated.

DISCUSSION: Findings have the potential to improve both jail- and community-based treatment services for adults with CODs as well as inform methods for conducting rigorous pilot implementation and evaluation research in correctional settings and as inmates re-enter the community. Findings will contribute to a growing area of work focused on interrupting the cycle of limited treatment engagement, unaddressed criminogenic risks, and (re)arrest among adults with CODs.

TRIAL REGISTRATION: ClinicalTrials.gov, NCT02214667 . Registered on 10 August 2014.

World Health Organization

INTERPERSONAL VIOLENCE AND ILLICIT DRUGS

(WORLD REPORT WHO, 2009)

Table 1: Global average estimates of use of selected illicit drugs by region, all people aged 15 to 64 years (2006 or latest year) (6)

Region	Cannabis		Amphetamines		Ecstasy		Cocaine		Heroin	
	Number of users (thousands)	%	Number of users (thousands)	%	Number of users (thousands)	%	Number of users (thousands)	%	Number of users (thousands)	%
EUROPE	29,200	5.3	2,490	0.5	2,947	0.5	4,008	0.8	3,130	0.6
Western/Central	22,100	6.9	1,950	0.6	2,624	0.8	3,895	1.2	1,370	0.4
South-East	1,700	2.0	180	0.2	204	0.2	67	0.1	130	0.2
Eastern	5,400	3.7	350	0.2	117	0.1	46	0.0	1,630	1.1
AMERICAS	40,500	6.9	5,670	1.0	3,094	0.5	10,196	1.7	1,520	0.3
North	30,600	10.5	3,720	1.3	2,367	0.8	7,097	2.4	1,270	0.4
South	9,900	3.4	1,960	0.7	727	0.3	3,099	0.8	250	0.1
ASIA	51,100	2.0	13,750	0.5	2,103	0.1	335	0.0	6,080	0.2
OCEANIA	3,200	14.5	470	2.9	706	3.2	301	1.4	30	0.1
AFRICA	41,600	8.0	2,260	0.4	199	0.0	1,147	0.2	1,210	0.2
GLOBAL	165,600	3.9	24,650	0.6	9,047	0.2	15,987	0.4	11,970	0.3

Illicit drug use and interpersonal violence are major public health challenges that are strongly linked

Involvement in drug use can increase the risks of being both a victim and/or perpetrator of violence, while experiencing violence can increase the risks of initiating illicit drug use

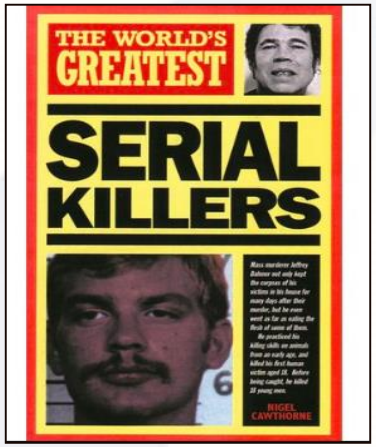
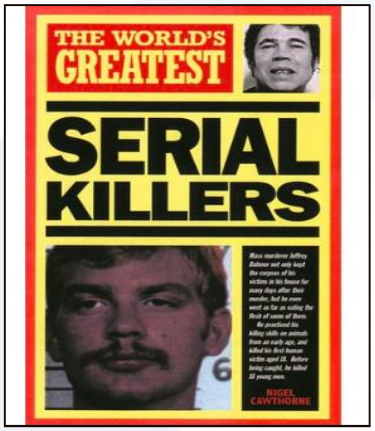


Table 5. Most Statistically Robust Predictors in Final Multivariate Model of Any Violent Behavior Between Waves 1 and 2

Predictor	Wald *F*	*P* Value	Risk Domain
Age, y	136.746	<.001	Dispositional
History of any violent act	109.932	<.001	Historical
Sex	67.231	<.001	Dispositional
History of juvenile detention	31.007	<.001	Historical
Divorce or separation in the past year	28.154	<.001	Contextual
History of physical abuse	27.492	<.001	Historical
Parental criminal history	21.162	<.001	Historical
Unemployment for the past year	15.453	<.001	Contextual
Co-occurring severe mental illness and substance use	13.342	<.001	Clinical
Victimization in the past year	8.204	.003	Contextual

Elbogen et al, Arch Gen Psychiatry 2009



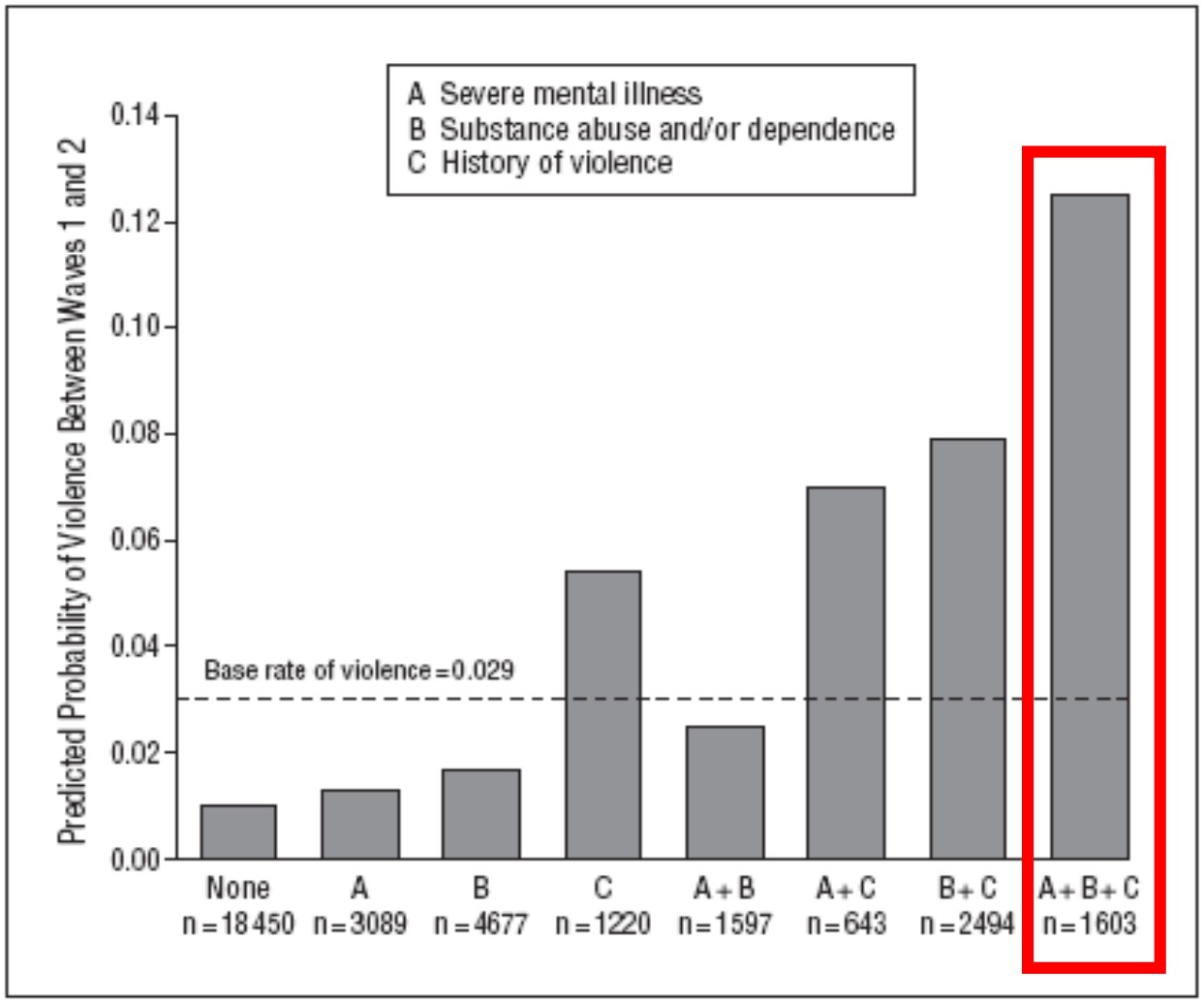


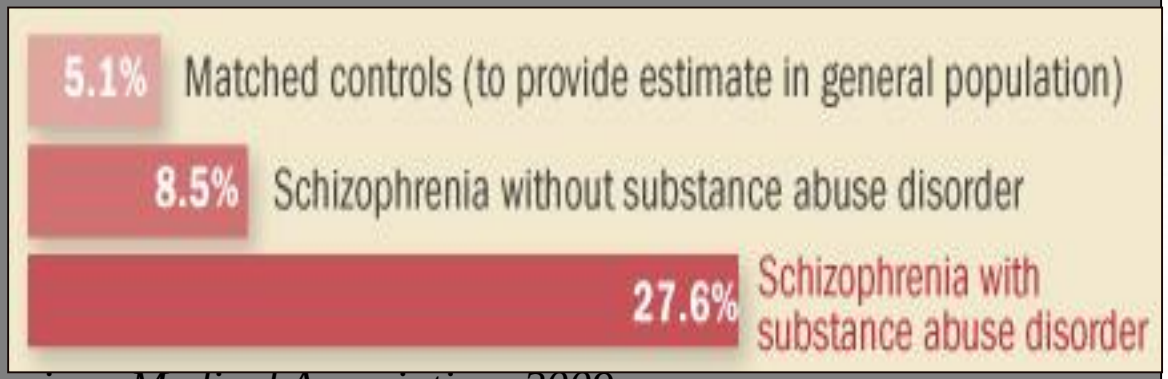
Figure. Predicted probability of any violent behavior between waves 1 and 2 as a function of severe mental illness, substance abuse and/or dependence, and history of violence.

Elbogen et al, Arch Gen Psychiatry 2009)

Rischio di reiterazione di reato violento

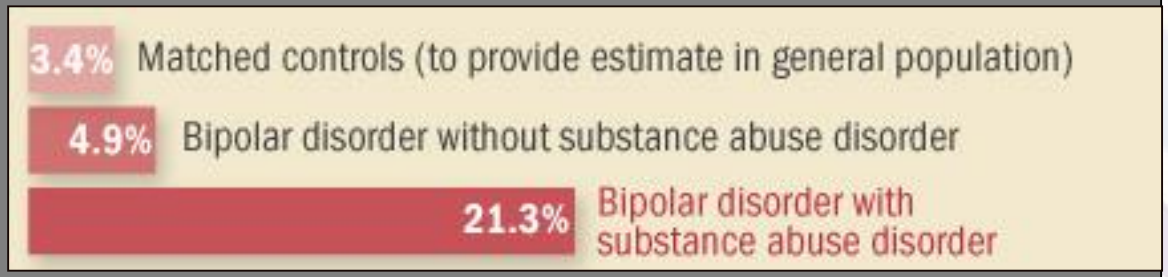
Persone coinvolte almeno una volta in un crimine violento

- **Schizofrenia**



Fazel et al, Journal of the American Medical Association, 2009

- **Disturbo bipolare**



Fazel et al, Archives of General Psychiatry, 2010

Risk Factors for Suicide, Near-Lethal Self harm, and self harm

Suicide (103)	Near-lethal Self Harm (7, 104)	Self harm (26)
Risk Factors	**Risk Factors**	**Risk factors**
Suicidal ideation	White ethnicity	Young age
Single cell occupancy	No educational qualifications	White ethnicity
History of attempted suicide	Prior prison spell	Sentence length <12 months
Current psychiatric diagnosis	Less than 30 days in prison	Life sentence
Psychotropic medication	Mood disorders	Detainee/remand status
Detainee/remand status	Anxiety disorders	Previous violent offence (women only)
Life sentence	Psychoses	
Murder/manslaughter offence	Drug use disorder	
Violent offence	Past psychiatric treatment	
Alcohol use problems	Previous self harm in prison	
Past contact with mental health services (105)	Previous self harm outside prison	
Being married before prison	Two or more psychiatric disorders	
Protective Factors		
Black race/ethnicity		
Length of sentence <18 months		
Sentenced		

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Lancet Psychiatry 2016; 3 (9); 871-81

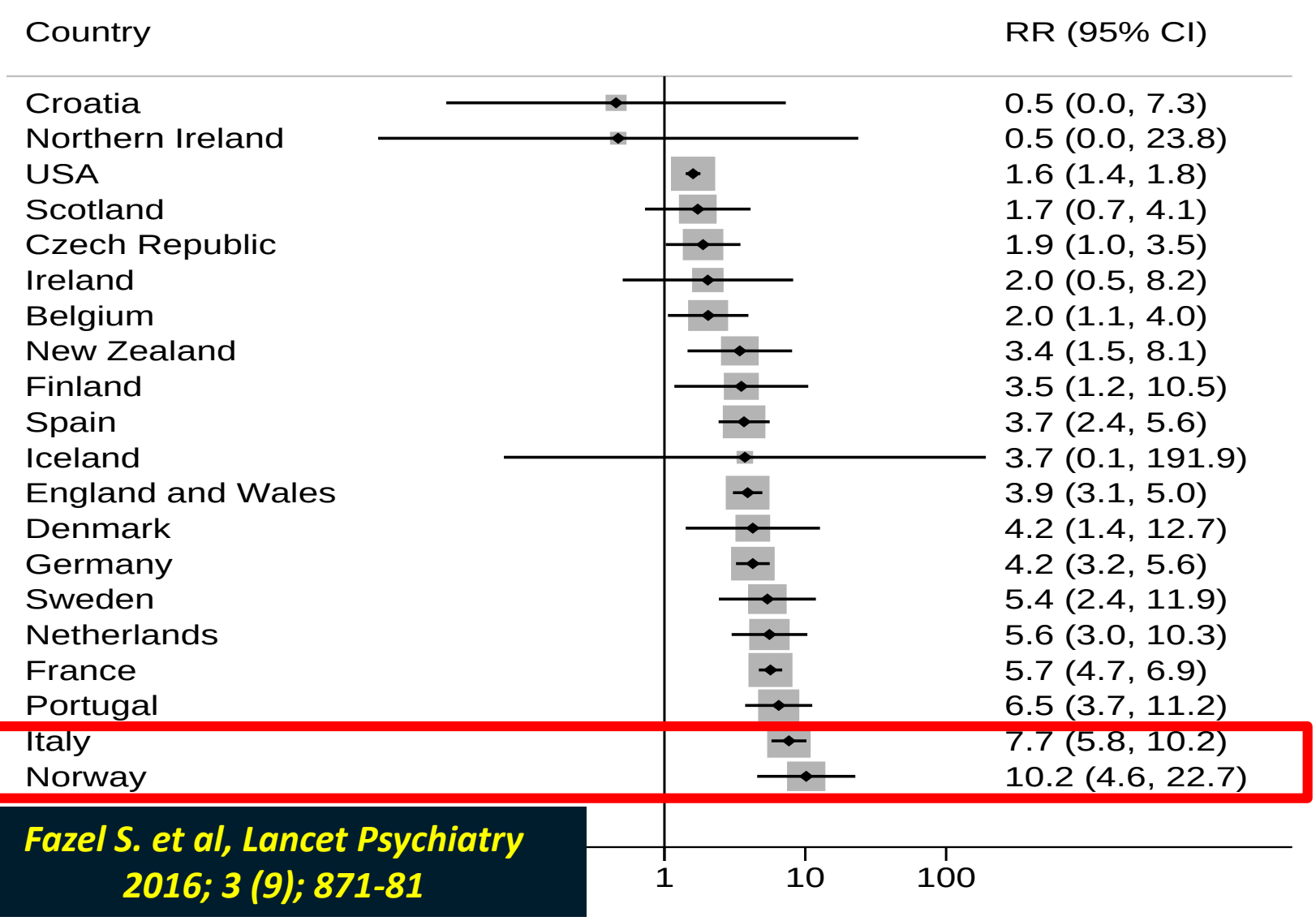
Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide

	2004	2005	2006	2007	2008	2009
Prison population*						
Male inmates	70209 (94%)	71512 (94%)	73680 (94%)	75842 (95%)	78158 (95%)	79276 (95%)
Female inmates	4448 (6%)	4467 (6%)	4447 (6%)	4374 (5%)	4414 (5%)	4283 (5%)
Total	74657 (100%)	75979 (100%)	78127 (100%)	80216 (100%)	82572 (100%)	83559 (100%)
Number of first receptions†						
Male inmates	120407 (91%)	119783 (91%)	117036 (91%)	114034 (91%)	121472 (91%)	114833 (91%)
Female inmates	12554 (9%)	12275 (9%)	11950 (9%)	11847 (9%)	12676 (9%)	11044 (9%)
Total	132961 (100%)	132058 (100%)	128986 (100%)	125881 (100%)	134148 (100%)	125877 (100%)
Incidents of self-harm‡						
Male inmates	9849 (104 per 1000)	10412 (113 per 1000)	11886 (129 per 1000)	11589 (123 per 1000)	12211 (125 per 1000)	13694 (122 per 1000)
Female inmates	9839 (1597 per 1000)	13368 (2190 per 1000)	11505 (1896 per 1000)	11408 (1871 per 1000)	13015 (2194 per 1000)	10419 (1615 per 1000)
Total	19688 (200 per 1000)	23780 (247 per 1000)	23391 (242 per 1000)	22997 (232 per 1000)	25226 (249 per 1000)	24113 (208 per 1000)
Individuals who self-harmed§						
Male inmates	4193 (5%)	4405 (5%)	4652 (5%)	4976 (5%)	5148 (5%)	5340 (6%)
Female inmates	1274 (20%)	1371 (22%)	1325 (22%)	1352 (23%)	1392 (24%)	1356 (21%)
Total	5467 (6%)	5776 (6%)	5977 (6%)	6328 (6%)	6540 (6%)	6696 (7%)
Ratio of incidents to individuals						
Male inmates	2·2	2·2	2·5	2·3	2·3	2·5
Female inmates	7·3	9·4	8·6	8·2	9·2	7·4
Overall	3·4	3·9	3·8	3·5	3·8	3·5

109 subsequent suicides in prison were reported in individuals who self-harmed; the risk was higher in those who self-harmed than in the general prison population, and more than half the deaths occurred within a month of self-harm. Risk factors for suicide after self-harm in male prisoners were older age and a previous self-harm incident of high or moderate lethality; in female inmates, a history of more than five self-harm incidents within a year was associated with subsequent suicide.

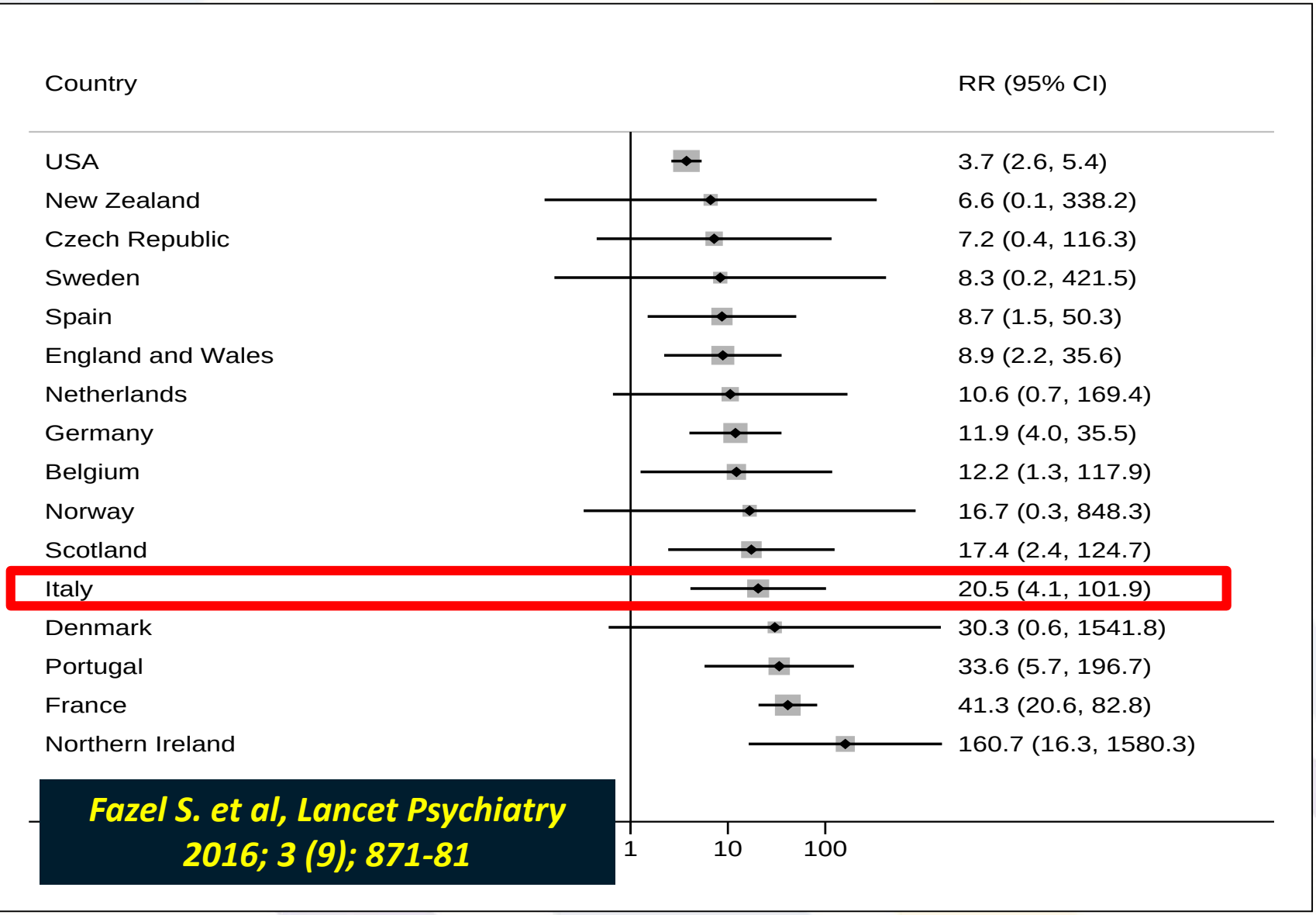
Hawton K.et al., The Lancet 2014; 29; 383;1147-54

Suicide in male prisoners



Fazel S. et al, Lancet Psychiatry 2016; 3 (9); 871-81

Suicide in female prisoners



Fazel S. et al, Lancet Psychiatry 2016; 3 (9); 871-81

Self-harm, suicide and Prisons in England and Wales (Fazel et al, 2005)

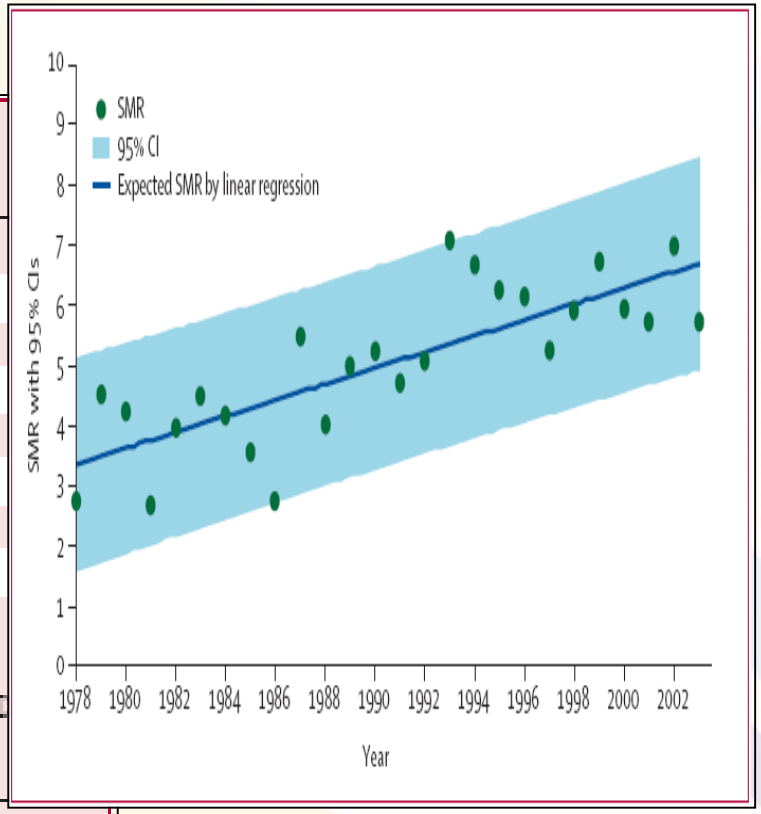
Studio della rilevanza del comportamento suicidario in 25 anni (1978-2003): n° 1312

SMR >4 in tutte le fasce di età

	Number of suicides	SMR (95% CI)
15–17	28	18 (13–26)
18–20	164	6·1 (5·3–7·2)
21–24	218	4·3 (3·7–4·9)
25–29	276	4·9 (4·4–5·6)
30–39	390	5·5 (5·0–6·1)
40–49	167	5·6 (4·8–6·5)
50–59	55	5·2 (4·0–6·8)
60+	14	4·4 (2·6–7·4)
Total	1312	5·1 (4·8–5·3)

95% CI calculated as SMR/EF to SMR*EF (where EF is the error factor=exp[1·96/√D and D=number of deaths).

Table: Standardised mortality ratios (SMR) of suicides in male prisoners by age band (in years), 1978–2003



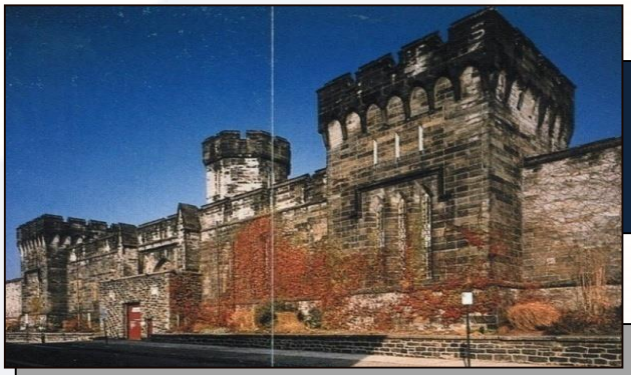
Risk factors for Prison Violence and Victimisation

Prison Violence (39)	Sexual Victimisation (34)	Physical Victimisation (106-109)
Risk Factors	**Risk Factors**	**Risk Factors**
Younger age	Mental disorder	Mental disorder
Minority ethnic group	Female	Younger age
Less formal education	Minority ethnic group	White ethnicity
Shorter sentence		Sexual offence
Gang affiliation		Past victimisation
Prior arrests		Gang involvement
Prior incarceration		Dissatisfaction with officers
Prior poor incarceration adjustment		
Aggression		
Psychopathology		
Less social support		
Major mental illness		
Psychopathy		
Substance misuse		
Dual diagnosis (MI and SU)		
Protective Factors		**Protective Factors**
Older age		Involvement in work programmes

Mental health of prisoners: prevalence, adverse outcomes, and interventions

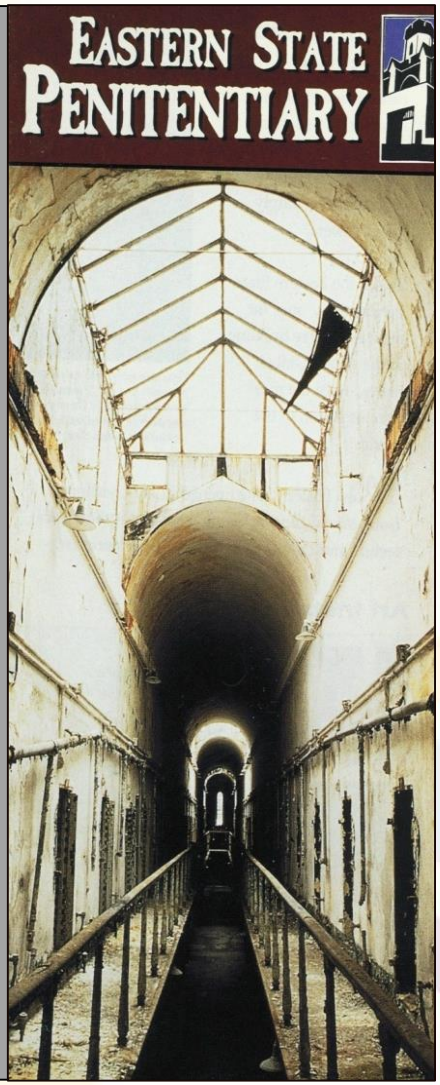
Seena Fazel, Adrian J Hayes, Katrina Bartellas, Massimo Clerici, Robert Trestman

Lancet Psychiatry 2016; 3 (9); 871-81



Segnalibro

- Carcere e disturbi mentali: un problema che viene da lontano
- Correlati clinici del reato: disturbi, sostanze, violenza e autolesività
- **Alcune esperienze di psichiatria penitenziaria**
- Un agenda per il futuro: implicazioni organizzative della salute mentale in carcere



Sistema Socio Sanitario

Ospedale San Gerardo

Regione Lombardia

ASST Monza

TR59 "Disagio Mentale e Carcere"

ALLEGATO 1

PROGRAMMA DI AZIONI INNOVATIVE
PER LA SALUTE MENTALE

Scheda sintetica di Programma

AVVISO PUBBLICO PER LO SVILUPPO DI PERCORSI A CARATTERE MULTIDISCIPLINARE PER LA REALIZZAZIONE DEI PIANI INTEGRATI DI INCLUSIONE SOCIALE DELLE PERSONE SOTTOPOSTE A PROVVEDIMENTI DELL'AUTORITA' GIUDIZIARIA – ADULTI E MINORI

Casa Circondariale di Monza (700 posti circa)

Dipartimento di Salute Mentale e Dipendenze (DSMD)

Cabina di Regia ATS

Piani di Intervento ASL/ATS Brianza
- Programma Innovativo TR59
- "Interventi psico-socio-educativi per adulti e minori sottoposti a provvedimenti dell'Autorità Giudiziaria e loro familiari"

Sistema Socio Sanitario

Ospedale San Gerardo

Regione Lombardia

ASST Monza

L'Unità di Salute Mentale in Carcere (già Psichiatria Pentenziaria) - C.C. Monza

ALLEGATO 1

PROGRAMMA DI AZIONI INNOVATIVE PER LA SALUTE MENTALE

Scheda sintetica di Programma

TR59 *"Disagio Mentale e Carcere"*

Prima Diagnosi (%)	
- **D. adattamento**	**29,2**
- D. personalità	**8,3**
- D. umore	12,3
- **D. uso sostanze**	9,4
- Altro	8,5
- D. ansia	7,5
- **D. psicotici**	**4,7**

Comorbità mediche	
Si	**68,9%**
No	31,1%
HCV	
Si	**18,5%**
No	81,5%
HIV Si	**5,0%**
No	95,0%
AIDS	1,7%

Tp medica t0	
Si	**45,8%**
- F. app. GI	48,1%
- F. app. CV	40,7%
- Analg-Apir.	35,2%
No	54,2%

Scale t0

GAF MRS

HAM-D HAM-A

BIS-11

Comorbità pre-arresto	
D. personalità	**52,4%**
D. umore	**42,9%**
D. ansia	4,8%
D. uso sostanze	9,5%
Ritardo mentale	4,8%

Comorbidità post-arresto	
Ep. depressivo maggiore	75,0%
D. adattamento	25,0%

Tp psichiatrica t0	
Benzodiazepine	**93,3%**
Antidepressivi	**54,3%**
Antipsicotici	**51,4%**
+ Neurolettico	18,5%
+ Atipico	55,6%
Atipico+Neurolettico	25,9%
Stabilizzanti umore	15,2%
Anticolinergico	2,9%

Item 1 CGI t0: **61,0%**

Normale, marginalmente o lievemente ammalato

Terapia psichiatrica a t0	
Poli-tp	**82,9%**
Mono-tp	17,1%

Sistema Socio Sanitario

Ospedale San Gerardo

Regione Lombardia

ASST Monza

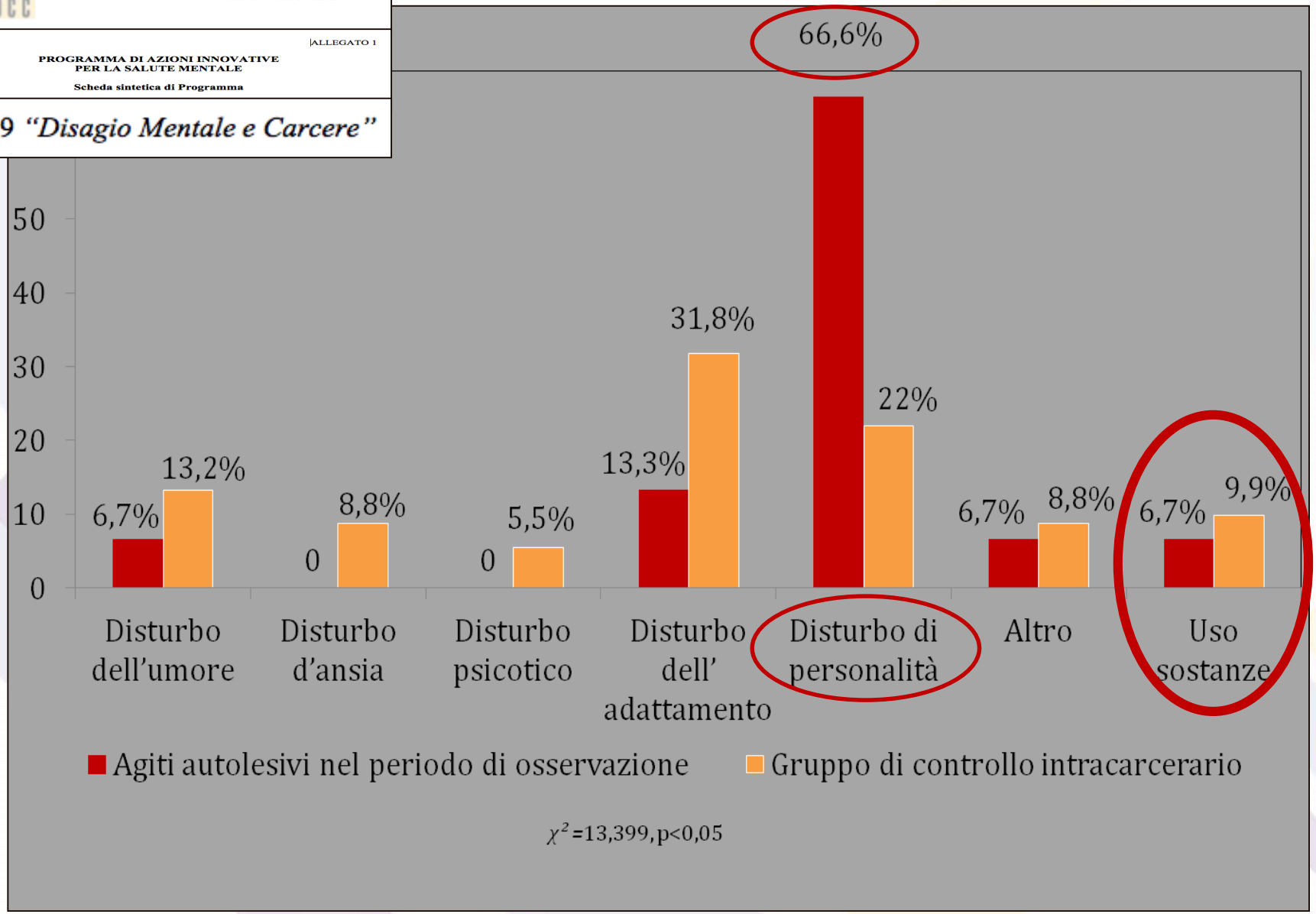
ALLEGATO 1

PROGRAMMA DI AZIONI INNOVATIVE
PER LA SALUTE MENTALE

Scheda sintetica di Programma

TR59 *"Disagio Mentale e Carcere"*

TS e diagnosi psichiatrica



Sistema Socio Sanitario
Ospedale San Gerardo
Regione Lombardia
ASST Monza

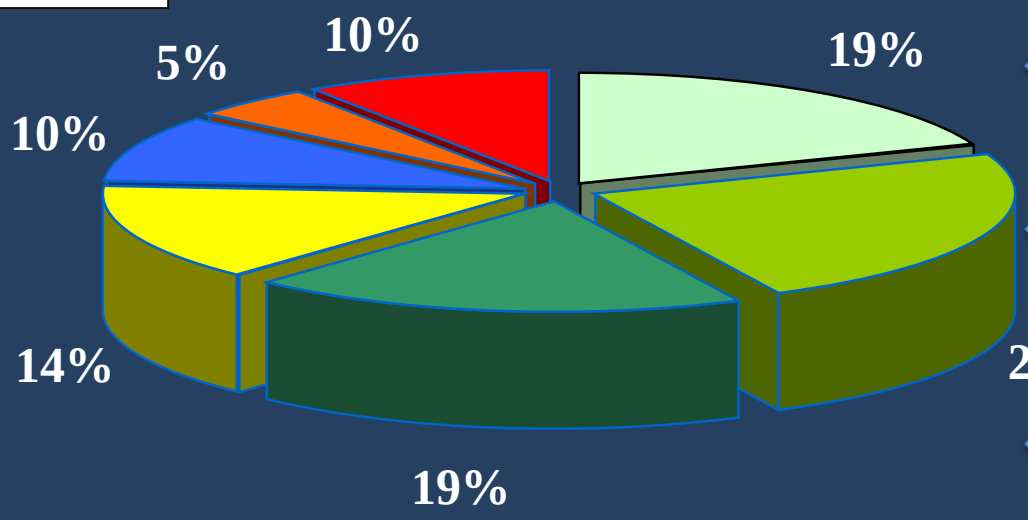
ALLEGATO 1

PROGRAMMA DI AZIONI INNOVATIVE
PER LA SALUTE MENTALE

Scheda sintetica di Programma

TR59 *"Disagio Mentale e Carcere"*

Tempistica agiti autolesivi



% di pazienti in carcere con agiti autolesivi nel primo mese:

61

- 1 settimana
- 2/3 settimana
- 3/4 settimana
- 8/16 settimana
- 36/40 settimana
- 44/52 settimana
- pre valutazione

STUDIO 1. CARCRE E AUTOLESIVITA' (1422 casi)

The number of self-injurious behaviors and suicide attempts were collected over a period of one year from the incarceration based on the official records of the Penitentiary Police Participants; there were 67 (4.8%) inmates who had at least one episode of self-injury during the period of observation and 28 (2.0%) inmates with at least one suicide attempt.

The differences among clusters in terms of self-injurious behaviors before incarceration were examined through chi-square tests. A significant association emerged ($X^2_{(3)} = 82.86$, $p < .001$) and standardized residuals indicated that the *dysregulated* cluster had a significant number of participants with prior self-injurious behaviors ($z = 7.5$) followed by the *impulsive* cluster ($z = 1.6$). On the contrary, the *well-*

ters showed a number of participants lower than expected (respectively,

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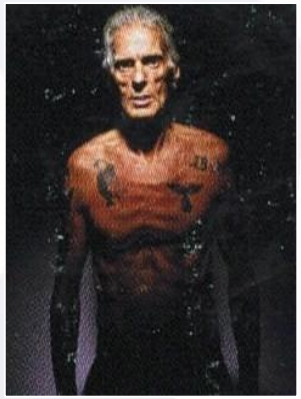
journal homepage: www.elsevier.com/locate/ijlawpsy

Pattern of self-injurious behavior and suicide attempts in Italian custodial inmates: A cluster analysis approach

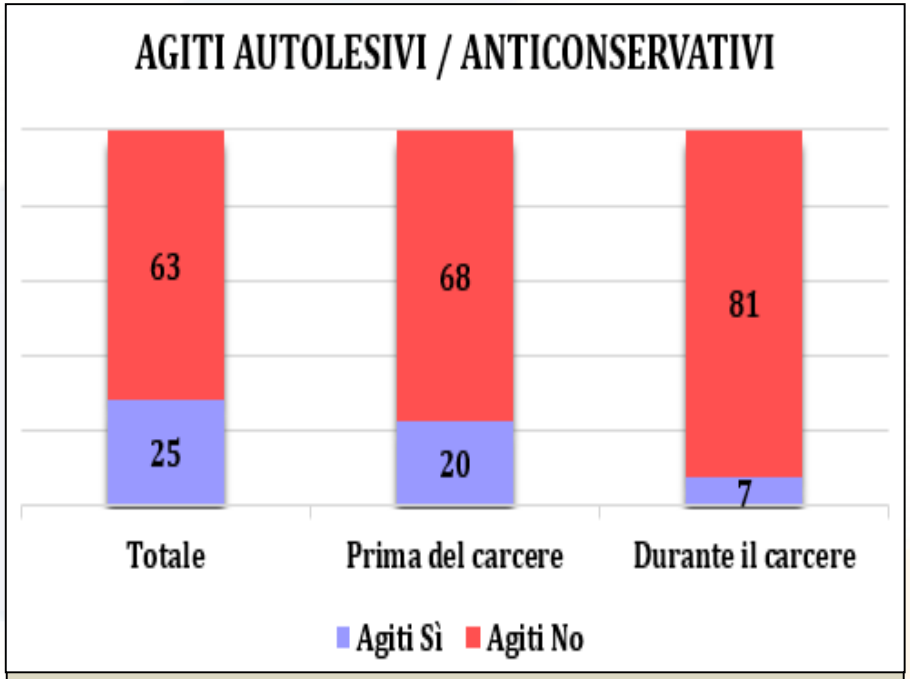
Marco Bani[a,*,1], Gabriele Travagin[b], Michele Monticelli[c], Manuela Valsecchi[d], Emanuele Truisi[d], Federico Zorzi[a], Mariagrazia Strepparava[a,d], Massimo Clerici[a,d], Umberto Mazza[e], Giorgio Rezzonico[a]

[a] Department of Medicine and Surgery, University of Milano - Bicocca, via Cadore 48, 20900 Monza, Italy
[b] Catholic University of Sacred Heart, Department of Psychology, Largo Agostino Gemelli, 1, 20123 Milan, Italy
[c] Catholic University of Sacred Heart, Department of Education, Largo Agostino Gemelli, 1, 20123 Milan, Italy
[d] Mental Health Department, ASST S. Gerardo Monza, via Pergolesi 33, 20900 Monza, Italy
[e] Clinical Psychology, Mental Health Department, Niguarda Hospital, piazza Ospedale Maggiore, 3, 20162 Milan, Italy

STUDIO 2. MALTRATTAMENTO INFANTILE, AUTO-AGGRESSIVITA' E CARCERE: FATTORI DI RISCHIO *LIFETIME*



- Prevalenza aumentata di Patologie psichiatriche
  (Fazel e Baillargeon, 2011)
- Maggiore utilizzo di Sostanze stupefacenti
  (Gates et al. 2017)
- Confinamento e allontanamento dai congiunti
  (Buffa et al., 2011)
- Vergogna e giudizio penale e morale
  (Duthé G. et al., 2009)
- Cella singola / regimi detentivi speciali / sovraffollamento carcerario
  (Fazel et al., 2008 – Hayes et al., 2006)
- Esposizione all'altrui aggressività
  (Duthè et al., 2014)
- Precedenti esperienze detentive
  (Björkenstam et al. 2011)



MATERIALE E METODI: L'INTERVISTA

- <u>Valutazione delle variabili indipendenti</u> (25 detenuti con agito autolesivo vs 63 controlli)
- Socio-demografiche
  Criminologiche
  Cliniche
  Tossicologiche

<u>Valutazione dell'Outcome</u>:

- Agiti autolesivi e/o TS
  lifetime

- <u>Valutazione della vittimizzazione</u>

- Childhood Trauma Questionnaire
  (CTQ – 28 item)

Abuso	**Neglect**
• Emotivo	Emotivo
• Sessuale	
• Fisico	Fisico

ANALISI UNI-VARIATA

Variabile	Agiti SI	Agiti NO	P value
Nazionalità IT	56.0%	77.8%	0.041 [b]
Anni di carcere	3.5	2.3	0.022 [c]
Diagnosi psich.	64.0%	17.5%	< 0.001 [b]
Comunità psich.	16.0%	1.6%	0.022 [b]
Terapia psich.	64.0%	38.1%	0.028 [b]
Abuso sostanze	88.0%	63.5%	0.036 [b]
N° sostanze	2.6	1.3	< 0.001 [a]

a = T-test; b = Chi2 square test o Fisher exact test; c = Test non parametrico di Mann-Whitney

Variabile	Agiti SI	Agiti NO	P value
SERT pre-CC	48.0%	19.1 %	0.006 [b]
Doppia Diagnosi	56.0%	11.1 %	< 0.001 [b]
Abuso Emotivo	1.3	0.1	< 0.001 [c]
Abuso Fisico	1.7	0.2	< 0.001 [c]
Abuso Sessuale	0.7	0.1	< 0.001 [c]
Neglect Emotivo	1.5	0.3	< 0.001 [c]
Neglect Fisico	1.4	0.3	<

INDICAZIONI OPERATIVE

1. **Vista la particolare condizione di rischio, nei detenuti si deve prestare particolare attenzione a rilevare questi fattori di rischio e attivare interventi specifici per i pazienti affetti da "doppia diagnosi" e abusati**
2. **La rilevanza delle correlazioni tra abuso fisico e/o sessuale e agiti autolesivi conferma l'utilità della valutazione precoce dei maltrattamenti infantili già nell'indagine da effettuarsi in prima giornata quando il detenuto è collocato nella sezione "Nuovi Giunti"**

Pertanto, l'anamnesi approfondita e la valutazione precoce della vittimizzazione infantile risulta fondamentale - in carcere - a fini preventivi: queste esperienze traumatiche sono infatti in grado di influenzare il funzionamento di chi l'ha subita o continua, durante la detenzione, a subirla e - per essa - ad incrementare il rischio di agiti, riacutizzazioni psicopatologiche ed utilizzo di sostanze

STUDIO 3. L'OSSERVAZIONE PSICHIATRICA

Art. 112 c.2 del DPR 230/2000

FATTORI PREDITTIVI DI INVIO IN STRUTTURE ALTERNATIVE ALLA DETENZIONE ORDINARIA (REMS) PER DETENUTI INVIATI ALL'ACCERTAMENTO DELLE INFERMITA' PSICHICHE IN CARCERE

Accertamento delle infermità psichiche

1. L'accertamento delle condizioni psichiche degli imputati, dei condannati e degli internati, ai fini dell'adozione dei provvedimenti previsti dagli articoli 148, 206, 212, secondo comma, del codice di procedura penale, dagli articoli 70, 71 e 72 del codice di procedura penale e dal comma 4 dell'articolo 111 del presente regolamento, è disposto, su segnalazione della direzione dell'istituto o di propria iniziativa, nei confronti degli imputati, dall'autorità giudiziaria che procede, e, nei confronti dei condannati e degli internati, dal magistrato di sorveglianza. L'accertamento è espletato nel medesimo istituto in cui il soggetto si trova o, in caso di insufficienza di quel servizio diagnostico, in altro istituto della medesima categoria.

2. L'autorità giudiziaria che procede o il magistrato di sorveglianza possono, per particolari motivi, disporre che l'accertamento sia svolto presso un ospedale psichiatrico giudiziario, una casa di cura e custodia o in un istituto o sezione per infermi o minorati psichici, ovvero presso un ospedale civile. Il soggetto non può comunque permanere in osservazione per un periodo superiore a trenta giorni.

3. All'esito dell'accertamento, l'autorità giudiziaria che procede o il magistrato di sorveglianza, ove non adotti uno dei provvedimenti previsti dagli articoli 148, 206 e 212, secondo comma, del codice di procedura penale o dagli articoli 70, 71, e 72 del codice di procedura penale e dal comma 4 dell'articolo 111 del presente regolamento, dispone il rientro nell'istituto di provenienza.

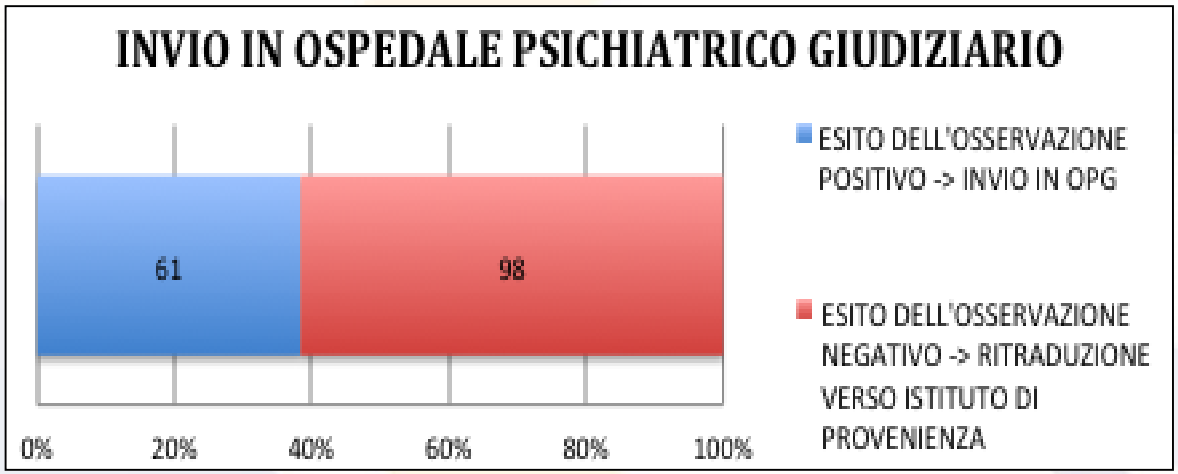
Esito POSITIVO: INVIO in (OPG) REMS/altre misure

Esito NEGATIVO: ritraduzione verso Istituto di provenienza

RISULTATI

DESCRITTIVA C.C. MONZA: invio in OPG

Nel campione in follow-up, **61 detenuti hanno avuto ESITO POSITIVO** dell'osservazione **con INVIO in strutture alternative** alla detenzione ordinaria (circa 40%) mentre 98 detenuti (circa 60%) hanno avuto **ESITO NEGATIVO** dell'osservazione con ritraduzione verso l'istituto di provenienza o analogo istituto di detenzione



Coerentemente con gli scopi dello studio, tutte le variabili raccolte sono state successivamente analizzate alla ricerca di associazioni che potessero identificare dei fattori predittivi di invio in OPG

RISCONTRI

NELLO STUDIO SONO STATE RILEVATE TRE VARIABILI ASSOCIATE ALL'INVIO IN OPG

- **PREGRESSI ACCESSI IN OSPEDALE PSICHIATRICO GIUDIZIARIO (OPG)**
- *** DIAGNOSI DI PSICOSI IN ASSE I**
- *** AGITI AUTOLESIVI E/O TENTATIVI SUICIDARI PRIMA DELL'INGRESSO IN CC**

Il risultato appare in linea con i principali dati sulla popolazione degli Ospedali Psichiatrici Giudiziari italiani presenti in letteratura che considerano questo dato tra i "***fattori giuridici di rilievo sanitario***"

(*MoDiOPG, Fioritti et al. 2006; rapporto 1123-3117 ISS 2011*)

Punto di forza - VARIABILE PREDITTIVA - è l' AFFIDABILITA' del dato reperibile con sicurezza già dal momento dell'ingresso in carcere del detenuto con una raccolta anamnestica di routine

STUDIO 4. OBIETTIVI, MATERIALI E METODI

- **Individuare le caratteristiche cliniche dei nuovi pazienti autori di reato ricoverati presso il "sistema polimodulare di REMS provvisorie di Castiglione delle Stiviere"**

- **Confrontarle con quelle della precedente popolazione OPG**

CAMPIONE

soggetti maschi residenti in Lombardia ricoverati a Castiglione delle Stiviere tra l'1aprile 2014 e il 31 marzo 2017

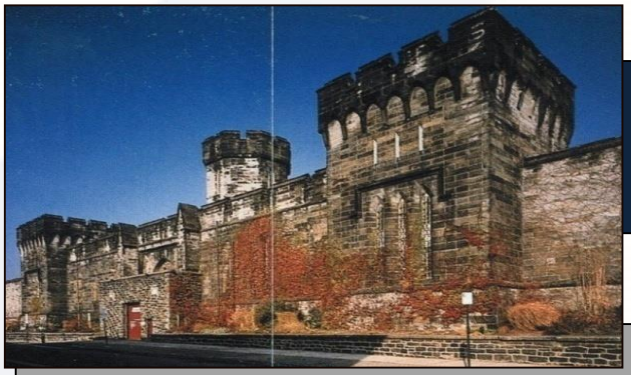
- **Gruppo A** (OPG): ingresso **1 aprile 2014 e il 31 marzo 2015**
- **Gruppo B** (REMS): ingresso **1 aprile 2015 e il 31 marzo 2016**
- **Gruppo C** (REMS): ingresso **1 aprile 2016 e il 31 marzo 2017**

Confronto operato:

- tra i gruppi A e B
- tra i gruppi A e C

RISULTATI

	Gruppo A	Gruppo B	Gruppo C	P value (A-B)	P value (A-C)
Età > 35 aa	42 (61,76%)	36 (52,94%)	33 (50,77%)	0,386	0,224
Asse I	43 (63,23%)	41 (60,29%)	37 (56,92%)	0,586	0,483
Asse II	25 (36,76%)	26 (38,23%)	28 (43,08%)	0.586	0,483
Uso di sostanze	37 (**54,41%**)	48 (**70,59%**)	50 (**76,92%**)	**0,051**	**0,010**
Presa in carico DSM	51 (75%)	55 (80,88%)	49 (75,38%)	**0,408**	1,000
Presa in carico precoce (NPI)	4 (**5,88%**)	14 (**20,59%**)	12 (**18,46%**)	**0,021**	**0,033**
Disabilità intellettiva	10 **(14,71%)**	16 **(23,53%)**	15 **(23,08%)**	0,275	0,269
Uso di sostanze e NPI	2 (**2,94%**)	13 (**19,12%**)	10 (**15,38%**)	**0,0046**	**0,0151**
Reato/persona	42 (61,76%)	43 (63,23%)	47 (72,31%)	0,579	0,204



Segnalibro

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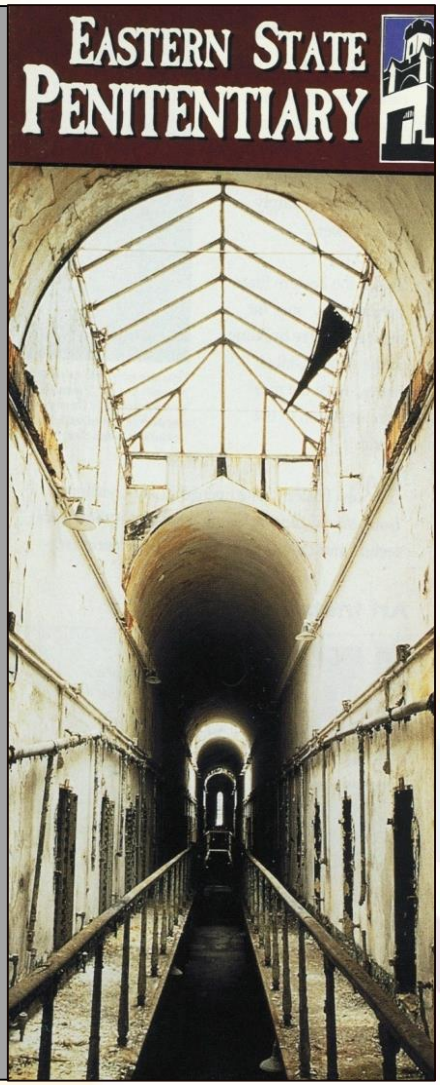
- **Un agenda per il futuro: implicazioni organizzative della salute mentale in carcere**



Mental health of prisoners: prevalence, adverse outcomes, and interventions

Seena Fazel, Adrian J Hayes, Katrina Bartellas, Massimo Clerici, Robert Trestman

Review

Statistics of prison population and management

54% Violent offenders of total prisoners (sentenced)

236:1 Ratio of prisoners to medical and paramedical staff

8% Prisoners referred for substance misuse interventions

€108 Amount spent per day per prisoner (pre-trial and sentenced)

N/A Cost per day for mental health treatments

27 Death rate (per 10 000 of prison population)

10 Suicide rate (per 10 000 of prison population)

	Risk factors	
Suicide [46]	Suicidal ideation; single cell occupancy; history o psychotropic medication; detainee or remand sta offence; alcohol use problems; past contact with	
Near-lethal self-harm [3,48]	White ethnicity; no educational qualifications; pr anxiety disorders; psychoses; drug use disorder; p previous self-harm outside prison; two or more psychiatric disorders	peaking with family/friends last 7 days
Self-harm [27]	Younger age; white ethnicity; sentence length <12 months; life sentence; detainee or remand status; previous violent offence (women only)	Black or Asian or Mixed race/ethnicity; residing in less secure or open prisons
Prison violence [41]	Younger age; minority ethnic group; less formal education; shorter sentence; gang affiliation; prior arrests; prior incarceration; prior poor incarceration adjustment; aggression; psychopathology; less social support; major mental illness; psychopathy; dual diagnosis (mental illness and substance misuse; substance misuse)	Older age
Physical victimisation [35,49-52]	Mental disorder; younger age; white ethnicity; sexual offence; past victimisation; gang involvement; dissatisfaction with officers	Involvement in work programmes
Sexual victimisation [53]	Mental disorder; female; minority ethnic group	None reported

Table 2: **Risk factors for suicide, near-lethal self-harm, self-harm, violence, and victimisation in prisoners**

Clinical Recommendations

Mental health of prisoners: prevalence, adverse outcomes, and interventions

Seena Fazel, Adrian J Hayes, Katrina Bartellas, Massimo Clerici, Robert Trestman

- Suicide prevention strategy including accurate screening and monitoring after arrival into prison, multi-disciplinary management of those at risk, and staff training.

- Accurate identification of those with serious mental health problems, including case finding on arrival to prison and allocation to appropriate level of service (i.e. primary/secondary/transfer to hospital)

- Evidence-based psychological and pharmacological mental health treatments that are available in the community or developed for prison settings should be provided

- Monitoring and effective management of drug and alcohol acute detoxification on arrival to prisons

- Methadone or alternative (e.g. Buprenorphine) maintenance therapy should be available in all prisons with effective coordination at discharge to the community

- Provision of CBT for relapse prevention of substance misuse

- Greater provision of trauma-focussed and gender-specific interventions

- Provision of meaningful daytime activity (education/courses/training)

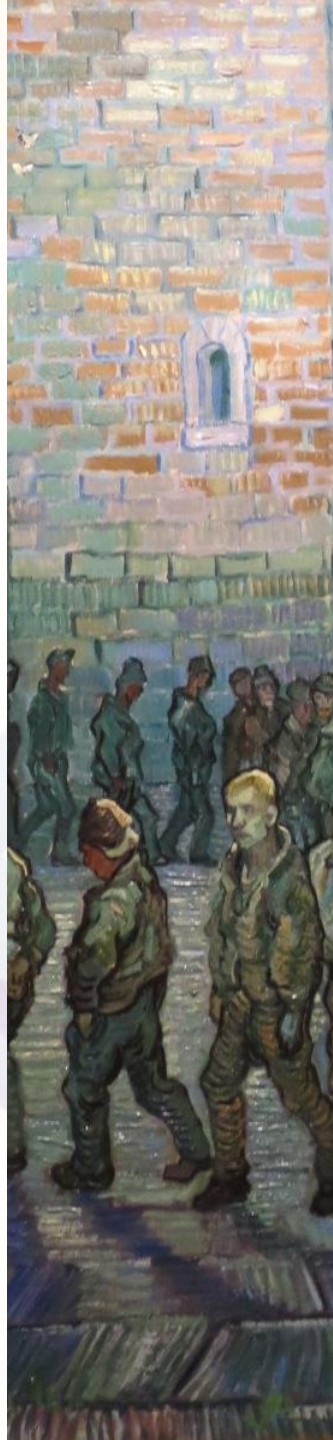
- Recognition for the different needs of older prisoners, with a strategy for their management

- Surveillance of deaths in prison including by suicide, overcrowding rates, prisoner-prisoner and prisoner-staff assault rates, self harm rates by gender, availability of methadone maintenance therapy, and research activity

TAKE HOME MESSAGES

- **Derivare profili clinici utili dallo STUDIO DEI "PERCORSI" DETENTIVI"** mediante dati affidabili, facilmente reperibili e sufficientemente standardizzati a livello regionale e nazionale permette di identificare - già dal momento dell'ingresso in carcere - specifiche sotto-popolazioni di ***detenuti problematici***;
- **"Pensare" PROGRAMMI DI TRATTAMENTO PERSONALIZZATI**
- **Identificare LUOGHI SPECIFICI, all'interno degli Istituti, dove garantire le esigenze di cura e di giustizia nel rispetto reciproco e a vantaggio del detenuto**

In quest'ottica di integrazione e collaborazione si deve rafforzare il lavoro clinico dei Servizi di Salute mentale del DSMD all'interno delle Istituzioni detentive



…grazie dell’attenzione!